AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF TENNESSEE)
)
COUNTY OF Rutherford)

Freya Brown, says as follows:

(a) That I am the duly authorized Custodian of the records for Deka Efobi, M.D. / Neurology Clinic Associates and have authority to certify said records;

(b) That the copy of the requested records on ~~Oliver Wolfenbarger~~ John Ruffino attached to this Affidavit is a true copy of all the records described in the accompanying letter dated January 10, 2017, and the signed Authorizations for Release of Protected Health Information;

(c) That the records were prepared by the personnel of this office in the ordinary course of business at or near the time of the act, condition, or event; and

(d) That the cost to furnish the copies of these records based on the usual charges of this office is $ 20.00 .

Freya Brown
(Signature of Affiant)

STATE OF TENNESSEE)
)
COUNTY OF Rutherford)

Sworn to and subscribed by me on this 20 day of January, 2017.

(Notary Public)

My Commission Expires: 9/20/2020

CALEB B BARRETT
STATE OF TENNESSEE NOTARY PUBLIC
RUTHERFORD COUNTY

EXHIBIT
tabbies
4

DEKA EFOBI M.D.

305 W Main Street
Lebanon, TN 37087
Phone : (615) 443-9912
Fax : (615) 443-9978
Email : drbrain@nca-md.com

Account No.: 332081 Patient Name: John J. Ruffino DOB: 06/12/1959

PERSONAL DETAILS:

Name	JOHN J. RUFFINO	**Gender**	MALE	**DOB**	06/12/1959
Address	1206 SOUTH 6TH STREET MAYFIELD, KY 42066			**E-mail**	
Home Phone No.	(248) 770-1584		**Cell Phone No.**	(248) 762-5356	
Emergency Contact Person			**Principal Doctor**	DEKA A. EFOBI M.D.	

PRIMARY INSURANCE:

Insurance Details	UNITED HEALTHCARE	**Insurance ID**	950404828
Address	P.O.BOX 740800 ATLANTA, GA 30374	**Subscriber Name**	JOHN J. RUFFINO
Phone No.		**Group No.**	904957

EEG (DOS: 02/16/2016)

Procedure: EEG

Evaluation Date: 02/11/2016. 41 minutes

Reason for Study: John J. Ruffino, a 57-year-old male, has been recommended EEG for transient alteration in awareness.

Technical Study : A posterior dominant rhythm was seen. At 11.This activity is of medium amplitude, symmetric and reactive to eye opening. Epileptiform activity was not seen.

Photic stimulation: No abnormal responses were seen.

Sleep: Patient attained stage II NREM sleep. Sleep potentials were symmetrical.

Impression: This is a normal EEG, while the patient was awake and asleep. Focal or lateralizing features were not seen during the recording. Generalized abnormalities were not seen during the recording. Epileptiform findings were not seen during the recording.

DEKA A EFOBI, M.D.

This report is electronically signed.

NEUROLOGY PROGRESS NOTE (DOS: 02/11/2016)

Account No.: 332081 Patient Name: John J. Ruffino DOB: 06/12/1959

Chief Complaints/Reason for Visit

Follow up visit on MRI, MRA and ECHO. Pt. Did not have blood work done. Also states he is still experiencing Mini stroke, headaches, memory loss and Difficulty swallowing at this time. No refill.

History of present Illness

Folow up. Had another TIA like spell. Worried

Review of System

- **Constitutional: Positive for fatigue.** Negative for fever, malaise, recent weight loss and recent weight gain.
- **Eyes: Positive for redness, pain / pressure and glasses.** Negative for vision changes, contacts lens, diplopia, blurred vision and drainage.
- **Ears: Positive for hearing loss.** Negative for tinnitus, headache, otalgia and vertigo.
- **Nose:** Negative for rhinorrhea, nasal congestion, epistaxis, sinusitis and ulcers.
- **Mouth:** Negative for shingles, mouth breathing, dry mouth, swelling of the lips, gum bleeding and Sore tounge.
- **Throat: Positive for snoring.** Negative for throat clearing, sore throat, difficulty speaking, throat infections, post nasal drip, feeling of tightness and throat pain.
- **Respiratory: Positive for shortness of breath.**
- **Cardiovascular:** Negative for palpitations, edema and angina.
- **Neurology: Positive for numbness, weakness of extremities, tingling and memory loss.** Negative for headaches, seizures, tremors, trouble walking, confusion, mood changes and giddiness.
- **Musculoskeletal: Positive for back pain, joint pain, weakness and H/O falls.** Negative for limited movement.
- **Psychiatric: Positive for depression and anxiety/panic attacks.**
- **Gastrointestinal:** Negative for diarrhea, constipation, dysphagia and reflux.
- **Genitourinary: Positive for frequent urination and urgency.** Negative for incomplete emptying and nocturia.
- **Skin:** Negative for rash.
- **Hematological: Positive for easy bruising.** Negative for lymphadenopathy.
- **Endocrine:** Negative for heat intolerance and cold intolerance.

History

Past Medical History: HTN.

Surgical History: Gallbladder removal Appendectomy.

Social History: He never consumes alcohol. He never consumes caffeine. Patient does not exercise regularly. Uses home smoke detector. He is married. He is a heavy cigarette smoker (20-39 cigs/day). Never consumes soda.

Family History: Father is deceased (cancer). Mother is deceased (cancer). Siblings are alive (2 brother cancer back pain). Children are alive (1 son good health).

Current Medications

Aspirin 81 mg tablet, dispersible qd oral, Flomax 0. 4 mg 1 capsule qd oral, Hydrochlorothiazide 25 mg 1 tablet qd oral, Lipitor 20 mg 1 tablet qd oral and Lisinopril 10 mg 1 tablet qd oral.

Allergies

NKDA.

General Physical Exam:
General appearance: Appears stated age and in no apparent distress.
Cardiovascular: S1 S2 regular rate and rhythm; No carotid bruits auscultated.

Musculoskeletal: Neck supple full range of motion of neck and back; Nontender to palpation of neck and back.
Head: Symmetric.
Eyes: No scleral icterus.
Ears: Bilateral tympanic membranes were pearly grey with good light reflex.
Nose: Nasal mucosa normal.
Throat: No lymphadenopathy, no signs of infection.
Neck: Supple. No thyromegaly and cervical nodes or JVD.
Peripheral vascular: Radial, dorsalis pedis and posterio tibialis pulses 2/4 bilaterally.
Respiratory: Lungs are normal to percussion and clear to auscultation.
Extremities: Right elbow tenderness on palpation.
Abdomen: Soft, non tender and not distended; there is no organomegaly; bowel sounds are heard.

Neurologic Exam:
Mental Status:
Alert: Alert.
Orientation: Oriented to person, place and time.
Attention & concentration: Attention and concentration is good.
Speech & language: Speech is fluent.
Comprehension: Comprehension is intact.
Repitition: Repitition is intact.
Naming: Naming is intact.
Long term memory: Long term memory appears good.
Short term memory: Short term memory appears good.
Mood and affect: Affect is appropriate.
Fund of knowledge: Fund of knowledge appears adequate.
Cranial Nerves:
I: Not tested.
II: Pupils equally round and reactive to light and accomodation; visual fields were full; fundus vasculature was normal and disk margins were normal.
III, IV & VI: Extraocular movements are intact.
V: Facial sensation was equal; jaw strength was intact.
VII: Face symmetric.
VIII: Hearing was grossly intact to voice and finger rub.
IX, X: Uvula was midline.
XI: Shoulder shrug, lateral head rotation was intact.
XII: Tongue was midline.
Muscle Strength: No pronator drift; fine finger movements intact; 5/5 upper extremity and lower extremity bilaterally.
Tone: Normal throughout.
Sensory: Intact to light touch throughout.
Reflexes: Reflexes are 2/4 throughout.
Babinski Reflex: Downgoing bilaterally.
Cerebellar: Finger to nose and heel to shin, rapid alternating movements intact bilaterally.
Gait: Normal heel to toe; negative romberg; tandem is intact.
Assessment

1. Transient cerebral ischemic attack, unspecified.
2. Transient alteration of awareness.
3. Other hyperlipidemia.
4. Essential (primary) hypertension.
5. Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter.
6. Abnormal brain scan.

Plan

1. Hypercoagulable Panel and Comprehensive ordered on 02/11/2016. EEG ordered on 02/11/2016.
2. I have prescribed him to take Neurontin 300 mg oral capsule qhs for 30 days (refills 1).
3. Patient with transient alteration in awareness and transient episoes of TIA like sx. His last one described as numbness with difficulty swallowing followed by fatigue and headaches. Will try low dose neurontin. MRI brain negative for infarct; PWMD ECHO, MRA ok- DDx partial seizures. Will get EEG. Still has not had hypercoagulable profile drawn. COntinue statins, antiplatelets.

4. EEGFperformed-see separate note
5. Return Visit:2/18/2016.
6. Time spent with patient:35.

DEKA A EFOBI, M.D.

This report is electronically signed.

NEUROLOGY PROGRESS NOTE (DOS: 02/11/2016)

Chief Complaints/Reason for Visit

Here for EEG

History

Past Medical History: HTN.

Surgical History: Gallbladder removal Appendectomy.

Social History: He never consumes alcohol. He never consumes caffeine. Patient does not exercise regularly. Uses home smoke detector. He is married. He is a heavy cigarette smoker (20-39 cigs/day). Never consumes soda.

Family History: Father is deceased (cancer). Mother is deceased (cancer). Siblings are alive (2 brother cancer back pain). Children are alive (1 son good health).

Current Medications

Aspirin 81 mg tablet, dispersible qd oral, Flomax 0. 4 mg 1 capsule qd oral, Hydrochlorothiazide 25 mg 1 tablet qd oral, Lipitor 20 mg 1 tablet qd oral, Lisinopril 10 mg 1 tablet qd oral and Neurontin 300 mg capsule qhs oral.

Allergies

NKDA.

General Physical Exam:

Vitals:
Sitting RA BP: 142/88 mmHg, **Respiratory Rate**: 16 per min, **Pulse Ox**: 98 %, **Pulse rate**: 74 per min and **Height**: 5' 4".

Assessment

1. Transient cerebral ischemic attack, unspecified.
2. Other hyperlipidemia.
3. Essential (primary) hypertension.
4. Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter.
5. Transient alteration of awareness.

Plan

1. I have prescribed him to take Folbic Vitamin B Complex with Folic Acid oral 1 tablet daily for 30 days (refills 12).
2. See separate report
3. Time spent with patient:45.

Aftercare

1. Patient family was counseled regarding treatment plans, medication adjustment and lifestyle recommendations to deal with the special needs of the patient.

DEKA A EFOBI, M.D.

This report is electronically signed.

NEUROLOGY PROGRESS NOTE (DOS: 12/14/2015)

Chief Complaints/Reason for Visit

New pt. Referred from Dr. Luck. Pt. States he is dealing with mini strokes.

History of present Illness

56 year-old RHCM with intermittent right sided heaviness and paresthesia ongoing for 2 months. HAs had 3 spells; first one occurd while walking in walmart and felt heaviness of RLE, two other episodes ocured while sitting, unable to use RUE. HAs dysarthria with all episodes and they last a few minutes. NO LOC, no confusiion, no headache. Now on aspirin, Takes

Review of System

- **Constitutional: Positive for fatigue.** Negative for fever, malaise, recent weight loss and recent weight gain.
- **Eyes: Positive for redness, pain / pressure and glasses.** Negative for vision changes, contacts lens, diplopia, blurred vision and drainage.
- **Ears: Positive for hearing loss.** Negative for tinnitus, headache, otalgia and vertigo.
- **Nose:** Negative for rhinorrhea, nasal congestion, epistaxis, sinusitis and ulcers.
- **Mouth:** Negative for shingles, mouth breathing, dry mouth, swelling of the lips, gum bleeding and Sore tounge.
- **Throat: Positive for snoring.** Negative for throat clearing, sore throat, difficulty speaking, throat infections, post nasal drip, feeling of tightness and throat pain.
- **Respiratory: Positive for shortness of breath.**
- **Cardiovascular:** Negative for palpitations, edema and angina.
- **Neurology: Positive for numbness, weakness of extremities, tingling and memory loss.** Negative for headaches, seizures, tremors, trouble walking, confusion, mood changes and giddiness.
- **Musculoskeletal: Positive for back pain, joint pain, weakness and H/O falls.** Negative for limited movement.
- **Psychiatric: Positive for depression and anxiety/panic attacks.**
- **Gastrointestinal:** Negative for diarrhea, constipation, dysphagia and reflux.
- **Genitourinary: Positive for frequent urination and urgency.** Negative for incomplete emptying and nocturia.
- **Skin:** Negative for rash.
- **Hematological: Positive for easy bruising.** Negative for lymphadenopathy.
- **Endocrine:** Negative for heat intolerance and cold intolerance.

History

Past Medical History: HTN.

Surgical History: Gallbladder removal Appendectomy.

Social History: He never consumes alcohol. He never consumes caffeine. Patient does not exercise regularly. Uses home smoke detector. He is married. He is a heavy cigarette smoker (20-39 cigs/day). Never consumes soda.

Family History: Father is deceased (cancer). Mother is deceased (cancer). Siblings are alive (2 brother cancer back pain). Children are alive (1 son good health).

Current Medications

Aspirin 81 mg tablet, dispersible qd oral, Flomax 0. 4 mg 1 capsule qd oral, Hydrochlorothiazide 25 mg 1 tablet qd oral, Lipitor 20 mg 1 tablet qd oral and Lisinopril 10 mg 1 tablet qd oral.

Allergies

NKDA.

General Physical Exam:
General appearance: Appears stated age and in no apparent distress.
Cardiovascular: S1 S2 regular rate and rhythm; No carotid bruits auscultated.
Musculoskeletal: Neck supple full range of motion of neck and back; Nontender to palpation of neck and back.
Head: Symmetric.
Eyes: No scleral icterus.
Ears: Bilateral tympanic membranes were pearly grey with good light reflex.
Nose: Nasal mucosa normal.
Throat: No lymphadenopathy, no signs of infection.
Neck: Supple. No thyromegaly and cervical nodes or JVD.
Peripheral vascular: Radial, dorsalis pedis and posterio tibialis pulses 2/4 bilaterally.
Respiratory: Lungs are normal to percussion and clear to auscultation.
Extremities: Right elbow tenderness on palpation.
Abdomen: Soft, non tender and not distended; there is no organomegaly; bowel sounds are heard.

Neurologic Exam:
Mental Status:
Alert: Alert.
Orientation: Oriented to person, place and time.
Attention & concentration: Attention and concentration is good.
Speech & language: Speech is fluent.
Comprehension: Comprehension is intact.
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Cranial Nerves:
I: Not tested.
II: Pupils equally round and reactive to light and accomodation; visual fields were full; fundus vasculature was normal and disk margins were normal.
III, IV & VI: Extraocular movements are intact.
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VII: Face symmetric.
VIII: Hearing was grossly intact to voice and finger rub.
IX, X: Uvula was midline.
XI: Shoulder shrug, lateral head rotation was intact.
XII: Tongue was midline.
Muscle Strength: No pronator drift; fine finger movements intact; 5/5 upper extremity and lower extremity bilaterally.

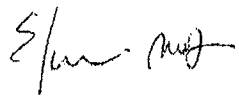
Account No.: 332081 Patient Name: John J. Ruffino DOB: 06/12/1959

Tone: Normal throughout.
Sensory: Intact to light touch throughout.
Reflexes: Reflexes are 2/4 throughout.
Babinski Reflex: Downgoing bilaterally.
Cerebellar: Finger to nose and heel to shin, rapid alternating movements intact bilaterally.
Gait: Normal heel to toe; negative romberg; tandem is intact.
Assessment

1. Transient cerebral ischemic attack, unspecified.
2. Other hyperlipidemia.
3. Essential (primary) hypertension.
4. Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter.

Plan

1. MRA Brain ordered on 12/14/2015. MRI BRAIN WITH AND W/O CONTRAST ordered on 12/14/2015. Hypercoagulable Panel and Comprehensive ordered on 12/14/2015. ECHO ordered on 12/14/2015.
2. Has had multiple episodes suggestive of TIA. Recently started aspirin and 1 since then. DDX:TIA vertebrobasilar syndrome, seizures. He as multiple risk factors for CVD: htn, hyperlipidemia, tobacco depe. Does not wish to stop smoking.
3.
4. Will initiate w/u. Continue aspirin, statins and good BP control. States he had lipid profile recently with PCP. Please get result.
5. Follow up after all above. May need eeg if all negative
6. Tennis elbow-followed by PCP
7. Return Visit:1/11/2016.
8. Time spent with patient:45.



DEKA A EFOBI, M.D.

This report is electronically signed.

Radiology Results

University Medical Center
1411 West Baddour Parkway, Lebanon, TN, 37087
Phone (615) 443-2583 Fax (615) 443-2536

Patient Name: RUFFINO, JOHN J

DOB:	06/12/1959	**Age:**	56 Y	**Patient Status:**	O	**Patient Type:**	O
Visit #:	3644371	**Sex:**	M	**Patient Location:**	OPR		
Acc.:	10016287			**Completed:**	12/23/2015		
Exam:	(884) MRAVBRWO - - MRA/MRV HEAD WO CONT						

Requesting Provider: EFOBI, DEKA, MD **MRN/Pt Num:** 0000764114

Attending Provider: EFOBI, DEKA, MD
305 WEST MAIN STREET
LEBANON, TN 37087

Diagnostic Report Text:

Clinical Diagnosis: CEREBRAL ISCHEMIC ATTACK/HYPERLIPIDEMIA ;TC:

PROCEDURE: MRA HEAD WITHOUT CONTRAST
TECHNIQUE: Axial 3-D time-of-flight MR angiography of the circle of Willis was performed. The source images were reconstructed in various views using maximum intensity projection. CPT 70544

HISTORY: Multiple episodes of right-sided weakness and aphasia .

COMPARISONS: None .

FINDINGS:
Vertebral arteries: Normal .
Basilar artery: Normal .
Internal carotid arteries: Normal .
Anterior cerebral arteries: Normal .
Middle cerebral arteries: Normal .
Posterior cerebral arteries: Normal . Posterior communicating arteries not identified.
Branch occlusions: None .
Vascular malformations: None .

IMPRESSION: No significant intracranial arterial abnormality. Posterior communicating arteries not identified.

Dictated By: Bernhard, Matthew
Signed By: Bernhard, Matthew

End of diagnostic report for accession: 10016287

Dictated By:	BERNHARD, MATTHEW, MI	
Transcribed By:	Interfac, Powerscribe884, 884TRANS	12/23/2015 1:00 PM CST
Signed By:	BERNHARD, MATTHEW, MD	12/23/2015 1:00 PM CST

Radiology Results

University Medical Center
1411 West Baddour Parkway, Lebanon, TN, 37087
Phone (615) 443-2583 Fax (615) 443-2536

Patient Name: RUFFINO, JOHN J

DOB:	06/12/1959	**Age:**	56 Y	**Patient Status:**	O	**Patient Type:**	O
Visit #:	3644371	**Sex:**	M	**Patient Location:**	OPR		
Acc.:	10016287			**Completed:**	12/23/2015		
Exam:	(884) MRAVBRWO - - MRA/MRV HEAD WO CONT						

Requesting Provider: EFOBI, DEKA, MD **MRN/Pt Num:** 0000764114

Attending Provider: EFOBI, DEKA, MD
305 WEST MAIN STREET
LEBANON, TN 37087

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PROCEDURE: MRA HEAD WITHOUT CONTRAST
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COMPARISONS: None .

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Middle cerebral arteries: Normal .
Posterior cerebral arteries: Normal . Posterior communicating arteries not identified.
Branch occlusions: None .
Vascular malformations: None .

IMPRESSION: No significant intracranial arterial abnormality. Posterior communicating arteries not identified.

Dictated By: Bernhard, Matthew
Signed By: Bernhard, Matthew

End of diagnostic report for accession: 10016287

Dictated By:	BERNHARD, MATTHEW, MI	
Transcribed By:	Interfac, Powerscribe884, 884TRANS	12/23/2015 1:00 PM CST
Signed By:	BERNHARD, MATTHEW, MD	12/23/2015 1:00 PM CST

Radiology Results

University Medical Center
1411 West Baddour Parkway, Lebanon, TN, 37087
Phone (615) 443-2583 Fax (615) 443-2536

Patient Name: RUFFINO, JOHN J

DOB:	06/12/1959	**Age:** 56 Y	**Patient Status:**	O	**Patient Type:** O
Visit #:	3644371	**Sex:** M	**Patient Location:**	OPR	
Acc.:	10016286		**Completed:**	12/23/2015	
Exam:	(884) MRBRWW -	- MR BRAIN W&WO CONT			

Requesting Provider: EFOBI, DEKA, MD **MRN/Pt Num:** 0000764114

Attending Provider: EFOBI, DEKA, MD
305 WEST MAIN STREET
LEBANON, TN 37087

Diagnostic Report Text:

Clinical Diagnosis: CEREBRAL ISCHEMIC ATTACK/HYPERLIPIDEMIA ;TC:

PROCEDURE: MRI BRAIN WITHOUT AND WITH CONTRAST
TECHNIQUE: Magnetic resonance imaging of the brain was performed before and after the IV injection of 0.1 mmol/kg paramagnetic contrast. CPT 70553

HISTORY: Multiple episodes of right-sided weakness, numbness, and aphasia.

COMPARISONS: None .

FINDINGS:
Skull base, calvarium and sinuses: Normal .
Cerebellum: No evidence of hemorrhage, ischemia or mass .
Brainstem: No evidence of hemorrhage, ischemia or mass .
Cerebrum: No evidence of hemorrhage, ischemia or mass . Multiple bilateral scattered nonspecific foci of T2/FLAIR signal hyperintensity, most pronounced within the right centrum semiovale and bilateral parietal temporal white matter.
Ventricles: .
Pituitary gland: Normal .
Globes and orbits: Normal .
Arterial and venous flow voids: Normal .
Abnormal enhancement: None .
Other: None .

IMPRESSION:
1. No evidence of acute intracranial abnormality.
2. Moderate nonspecific chronic white matter disease as detailed above, likely microangiopathic changes .

CRITICAL VALUE: No

Dictated By: Bernhard, Matthew
Signed By: Bernhard, Matthew

TriStar StoneCrest
MEDICAL CENTER

Patient: John Ruffino Medical Record Number: SM00254095

Facility: Tristar StoneCrest Medical Center Phone Number: 615-768-2800

Address: 200 Stonecrest Blvd City/State: Smyrna,TN Zip: 37167

CERTIFICATION OF MEDICAL RECORDS

To the best of my knowledge, the copied documents, records and other items enclosed are true and correct copies of all original records identified and described in the subpoena duces tecum, patient authorization, or court order made by or at the direction of the custodian of records. The original records were prepared in the ordinary course of the facility's regularly conducted business at or near the time of the act, condition, or event by persons with knowledge of the facts recorded, and the records have been maintained in the ordinary course of the facility's regularly conducted business according to all confidentiality and security requirements of law. This certification is given by the custodian of records instead of the custodian's personal appearance.

We are not aware of any omissions; however, due to the timing of this request it is possible that a portion of the medical record may be incomplete and/or preliminary at this time.

The recipient of these records agrees to maintain their confidentiality and permit further disclosure only as authorized by law.

Select Only One:

☑ The complete records consisting of 81 pages.

The complete records for the time period beginning _____ and ending _____consists of ____pages.

CERTIFICATION OF NO RECORDS

☐ A thorough search of requested information carried out under my direction and control revealed that this facility does not have the records described in the patient authorization or the subpoena duces tecum.

DECLARATION OF CUSTODIAN OF RECORDS

I, Melissa Gannon, am the duly authorized Custodian of Records of the above named facility. I am familiar with the mode of preparation of, and have the authority to certify, the facility record. I declare under penalty of perjury under the laws of the State of Tennessee, County of Rutherford that the foregoing is true and correct.

Melissa Gannon
Signature

1/5/2017
Date

Subscribed and sworn to me, a notary public in and for said county, this 5 Day of January 2017

Notary Public

My commission expires: June 17, 2018

MELINDA EDDY
STATE OF TENNESSEE
NOTARY
(Seal) C
RUTHERFORD COUNTY

Scan

PHYSICIAN

Emergency Medical Condition (EMC) Identified: (Mark appropriate box; have physician certify if I.c or I.d selected and then go to Section II.)

I. MEDICAL CONDITION: Diagnosis: CVA

a. ☐ **No Emergency Medical Condition Identified:** This patient has been examined and an EMC has not been identified.
Screening Physician Signature: _____ Date: ___/___/___ Time: _____ AM/PM

b. ☐ **Unstable Patient, Request for Transfer:** The patient has been examined and an EMC has been identified and the patient is not stable. The hospital has the capability and capacity to provide the care needed but the patient has specifically requested to be transferred to another facility after being notified that the hospital can and is willing to provide the care needed to stabilize and treat the EMC.

c. ☒ **Patient Stable For Transfer:** The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

d. ☐ **Patient Unstable:** The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

I.c and I.d Physician Certification: *I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.*
Physician Signature: C. Ahmed Date: 2/17/16 Time: 1656 AM/PM
Signature applies to any checked boxes.

II. REASON FOR TRANSFER:
☑ Medically Indicated ☑ Patient Requested (see patient request documentation: Section VII)
☐ On-call physician refused or failed to respond within a reasonable period of time.
On-Call Physician Name: _____ Address: _____

III. RISKS AND BENEFITS FOR TRANSFER:

Medical Benefits:	Medical Risks:
☒ Obtain level of care/service unavailable at this facility.	☑ Deterioration of condition in route.
Service: Neuro ICU	☑ Worsening of condition or death if you stay here.
☐ Medical benefits outweigh the risks.	☑ Risk of traffic delay/accident resulting in condition deterioration or death.
☐ Other:	☐ Other:

IV. MODE/SUPPORT DURING TRANSFER AS DETERMINED BY PHYSICIAN:
Mode of transportation for transfer: ☐ BLS ☒ ALS ☐ Helicopter ☐ Neonatal Unit ☐ Other: _____
Agency: Rutherford Name/Title of accompanying hospital employee if required: _____
Support/Treatment during transfer: ☒ Cardiac Monitor ☒ Oxygen: 2L ☐ IV Pump
IV Fluid: Saline lock Rate: _____ ☐ Restraints – Type: _____ ☐ Other: _____ ☐ None
Transferring Physician Signature if different from Certifying Physician: _____ Date: ___/___/___ Time: _____ AM/PM
If no physician immediately available, transfer authorized by Qualified Medical Provider per Dr. _____
QMP Signature: _____ Date: ___/___/___ Time: _____ AM/PM
Authorizing Physician Signature: _____ Date: 2/17/16 Time: _____ AM/PM

NURSING

V. RECEIVING FACILITY AND INDIVIDUAL: The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.
✓ Receiving Facility: Centennial Person accepting TXFR: Bahr Date: ___/___/___ Time: _____ AM/PM
✓ Receiving MD: Bahr Date: 2/17/16 Time: 1657 AM/PM
Questions regarding Medication Reconciliation Information may be directed to Bahr or Transferring Physician.

VI. ACCOMPANYING DOCUMENTATION sent via: ☐ Patient/Responsible Party ☐ Fax ☒ Transporter
Documentation includes: ☐ Copy of Medical Record ☒ Lab/ EKG/ X-Ray ☒ Copy of Transfer Form
☒ Medication Reconciliation Information ☐ Advanced Directive ☐ Other: _____
Report given to: (Person/title): Felicia Schuch, RN
Time of Transfer: 2205 Date: 2/17/16 Nurse Signature: [signature] Transferring Unit: ED
Vital Signs Just Prior to Transfer: Temp: 97.9 Pulse: 69 R: 18 BP: 150/85 spO2% 97% FHT: _____ Time: 2150 AM/PM

PATIENT

VII. PATIENT CONSENT TO MEDICALLY INDICATED TRANSFER or PATIENT REQUEST FOR TRANSFER:
☒ I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits of this transfer.
☐ I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's EMTALA responsibilities that have been explained to me, the medical risks and benefits of transfer and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician or anyone associated with the hospital. I agree to accept the risks associated with my decision.
The reason I request transfer is: _____
Signature of: ☒ Patient ☐ Responsible Person: [signature] Relationship to patient: self
Witness: [signature] Title: RN Date: 2/17/16 Time: 2205 AM/PM

EDPRS

PATIENT IDENTIFICATION.
RUFFINO, JOHN JAMES
SM0509454079 ADM INo SM.ER05
02/17/16 0949 Bennett, Julian MD
DOB: 06/12/59 56 M MR# SM00254095
STONECREST MEDICAL CENTER

PRINTED BY: bpage006 DATE 1/30/2017

STONECREST MEDICAL CENTER (COCSY)
EMERGENCY PROVIDER REPORT
REPORT#:0217-0175 REPORT STATUS: Signed
DATE:02/17/16 TIME: 1400

PATIENT: RUFFINO,JOHN JAMES
ACCOUNT#: SM0509454079
AGE: 56 SEX: M
FAMILY PHYSICIAN
SERVICE DT: 02/17/16
REP SRV DT: 02/17/16
UNIT #: SM00254095
ROOM/BED: SM.ER05-A
PCP PHYS: NO PRIMARY OR
AUTHOR: Archer,Clark E MD
REP SRV TM: 1400
* ALL edits or amendments must be made on the electronic/computer document *

See Addendum

HPI-Stroke/CVA

General
Initial Greet Date/Time 02/17/16 0958
Assumed Care at
Time 1220

Presentation
Chief Complaint: Right Side Weakness, face, slurred speech
Sudden in Onset? Yes (0830)
Onset Occurred Today
Symptom Duration Since onset
Progression since Onset Waxes and wanes
Location Face
Radiation Does not radiate
Exacerbated by Nothing
Relieved by Nothing

Context
Recent Healthcare Recent testing, Previous diagnosis, Prior workup

Risk-Stroke/CVA

Risk Stratification
NIH Stroke Scale
Value 4

Review of Systems

ROS Statements

PRINTED BY:bpa9869 DATE 1/5/2017

All systems rev & neg except as marked.

Past Medical History - Adult

Stated Complaint DIZZINESS
Allergies
Coded Allergies:
No Known Allergies (02/17/16)

Past Medical History:
Reports: Hyperlipidemia, Hypertension.
Past Surgical History:
Reports Cholecystectomy
Patient History
Relation not specified for:
Family History: Unremarkable

Smoking status for patients 13 Current every day smoker

Physical Exam

Initial Vital Signs

Vital Signs
First Documented:

	Result	Date Time
Pulse Ox	97	02/17 0956
B/P	187/89	02/17 0956
Temp	97.7	02/17 0956
Pulse	66	02/17 0956
Resp	189	02/17 0956

Last Documented:

	Result	Date Time
Pulse Ox	97	02/17 1222
B/P	150/79	02/17 1222
Pulse	56	02/17 1222
Resp	16	02/17 1222
Temp	97.7	02/17 0956

All vital signs available at the time of this entry have been reviewed.

Basic Physical Exam

Basic PE ENT: Membranes moist, ABD: Soft/non-tender, ABD: Normal bowel sounds, LYMPH: No adenopathy, EXT: NL inspection, EXT: Neurovascular intact, SKIN: No rashes, warm/dry, PSYCH: NL thought content

Focused PE

General/Const **
General/Const Awake, Alert, Well appearing, Well developed, Well hydrated
Head/Eyes **
Head/Eyes Atraumatic, Normocephalic, PERRL, EOMI, No nystagmus
ENT
ENT Atraumatic, Airway patent, Mucous membranes moist, Pharynx NL, No peritonsillar abscess
Neck **
Neck Atraumatic, Supple, No meningismus, Full range of motion, No adenopathy
Resp/Chest **
Respiratory/Chest Atraumatic, Breath sounds NL, Breath sounds = bilat, No respiratory distress, No rales, No rhonchi, No wheezing, No retractions
Cardiovascular **
Cardiovascular Heart rate NL, Regular rhythm, Heart sounds NL, No gallop, No murmurs
Abdomen/GI
Abdomen/GI Atraumatic, Soft, Non-tender, McBurney's non-tender, No guarding
Neurologic **
Neurologic Oriented X3
Speech
Slow, Slurred.

Interpretation & Diagnostics

Lab Results Interpretation

Results
Laboratory Tests

02/17/16 1015:

6.6	14.4 / 41.7 L	226

137	100	17	121 H
3.7	25	1.1	

Patient: RUFFINO,JOHN JAMES
Unit#:SM00254095
Date: 02/17/16
Acct#:SM0509454079

Laboratory Tests:

	02/17 1015	02/17 1200
Chemistry		
Sodium (136 - 145 mmol/L)	137	
Potassium (3.5 - 5.1 mmol/L)	3.7	
Chloride (98 - 107 mmol/L)	100	
Carbon Dioxide (23 - 29 mmol/L)	25	
Anion Gap	12	
BUN (6 - 20 mg/dL)	17	
Creatinine (0.9 - 1.3 mg/dL)	1.1	
GFR Calculation	89	
Glucose (74 - 106 mg/dL)	121 H	
Calcium (8.6 - 10.0 mg/dL)	9.1	
Total Bilirubin (0.3 - 1.2 mg/dL)	0.8	
AST (8 - 40 U/L)	20	
ALT (10 - 40 U/L)	22	
Alkaline Phosphatase (38 - 126 U/L)	71	
CK-MB (CK-2) (0.3 - 4.0 ng/mL)	1.6	
Troponin I (0.00 - 0.03 ng/mL)	0.01	
Total Protein (6.4 - 8.3 g/dL)	6.9	
Albumin (3.5 - 4.8 gm/dL)	4.0	
Globulin (gm/dL)	2.9	
Albumin/Globulin Ratio	1.4	
Coagulation		
INR (0.9 - 1.1)	0.95	
PT Patient/Control Mix (9.5 - 11.6 SECONDS)	10.1	
Hematology		
WBC (3.5 - 12.5 k/uL)	6.6	
RBC (4.5 - 6.1 M/uL)	4.84	
Hgb (14.0 - 17.5 g/dL)	14.4	
Hct (42.0 - 52.0 %)	41.7 L	
MCV (80 - 100 fL)	86.2	
MCH (25 - 34 pg)	29.8	
MCHC (32 - 36 g/dL)	34.5	
Plt Count (145 - 483 k/uL)	226	
Neutrophils % (35 - 83 %)	70.2	
Lymphocytes % (13.5 - 45.1 %)	20.8	
Monocytes % (0 - 14 %)	7.7	
Eosinophils % (0 - 6 %)	1.1	
Basophils % (0 - 2 %)	0.2	
Toxicology		

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Urine Opiates Screen (NEGATIVE)		NEGATIVE
Ur Methadone, Qual (Negative)		NEGATIVE
Ur Barbiturates, Qual (NEGATIVE)		NEGATIVE
Ur Amphetamine Screen (NEGATIVE)		NEGATIVE
U Benzodiazepines Scrn (NEGATIVE)		NEGATIVE
Urine Cocaine (NEGATIVE)		NEGATIVE
Urine Cannabinoids (NEGATIVE)		NEGATIVE
Urines		
Urinalysis		MICRO NOT PERFORMED
Urine Color (YELLOW)		Straw
Urine Appearance (CLEAR)		Clear
Urine pH (5.0 - 8.0)		6.0
Ur Specific Gravity (1.001 - 1.035)		1.011
Urine Protein (NEG MG/DL)		Negative
Urine Glucose (UA) (NEG MG/DL)		Negative
Urine Ketones (NEG)		Negative
Urine Blood (NEG)		Negative
Urine Nitrite (NEG)		Negative
Urine Bilirubin (NEG)		Negative
Urine Urobilinogen (NEG MG/DL)		<0.2
Ur Leukocyte Esterase (NEG)		Negative

Recent Impressions:
COMPUTERIZED TOMOGRAPHY - CT HEAD W/O CONTRAST 70450 02/17 1000
*** Report Impression - Status: SIGNED Entered: 02/17/2016 1037

Impression: There is no acute intracranial abnormality. Otherwise as above..
Impression By: DR.PARKE1 - Keith R. Parker, MD
RADIOLOGY - XR CHEST 1 VIEW PORT 71010 02/17 1014
*** Report Impression - Status: SIGNED Entered: 02/17/2016 1017

IMPRESSION: Slightly limited by suboptimal inspiration, but no abnormality is demonstrated.

Impression By: DR.BAKJA - Jack R. Baker, MD

Re-Evaluation & MDM

ED Course
Medication(s) Ordered
Medication(s) Ordered:
Electrolytic, Caloric, And Wat

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Sodium Chloride	3 ML	ASDIR PRN IV	02/17 1001 04/17 1000	AC	

Consultation
Consultation
Consultant Called Neurology
Call Returned Call returned

Patient Discharge & Departure

Vital Signs/Condition
Vital Signs
First Documented:

	Result	Date Time
Pulse Ox	97	02/17 0956
B/P	187/89	02/17 0956
Temp	97.7	02/17 0956
Pulse	66	02/17 0956
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Pulse	56	02/17 1222
Resp	16	02/17 1222
Temp	97.7	02/17 0956

All vital signs available at the time of this entry have been reviewed.

Clinical Impression
Clinical Impression
Primary Impression: TIA / CVA SYNDROME, ACUTE

Disposition Decision
Admit
)(**Admission Accepts** Yes
)(**Accepted Time** 1411
)(**Accepted Date** 02/17/16
Call Information will see patient

Critical Care
Time Spent 30-74 minutes
Services Performed Patient management by me, Time spent at bedside, Reviewing test results, Reviewing imaging, Discussing patient care, Documentation in record, Time with fam/surrogate, no tpa recommended by dr chitturi:

Electronically Signed by Archer,Clark E MD on 02/17/16 at 1411

Addendum 1: 02/17/16 1608 by Archer,Clark E MD

DISCUSSIONS WITH DR FRANKLIN/CHITTURI: FELT BEST FOR TRANSER DOWNTOWN TO HIGHER LEVEL OF CARE / NEURO ICU. PT AND FAMILY REQUESTING SAME.

Electronically Signed by Archer,Clark E MD on 02/17/16 at 1609

RPT #: 0217-0175
END OF REPORT

Patient: RUFFINO,JOHN JAMES Age/Sex: 56/M Acct No: SM0509454079
ED Provider: Archer,Clark E MD ED Room: Unit No: SM00254095

GENERAL DATA

ED Physician: Archer,Clark E MD, 2hcaActive Arrival Date/Time: 02/17/16 - 0948
Practitioner: Triage Date/Time: 02/17/16 - 0956
Nurse: TELEGDY,HAYLEY, RN Date of Birth: 06/12/1959

Stated Complaint: DIZZINESS
Chief Complaint: Vertigo/Dizziness Priority: 3

ALLERGIES

Allergy/Adverse Reaction	Type/Category	Severity	Date	Ver
No Known Drug Intolerances	Allergy/Drug	Unknown	02/17/16	Y

ASSESSMENTS

RAPID INITIAL Asmt w/Sepsis

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	0956	McCulloch,Carol A., RN	02/17/16	0958	McCulloch,Carol A., RN

First Point of Contact: Yes
Enter/Edit ALLERGIES: Yes
Arrived By: AMB
EMS Service: RUTH
Subjective Assessment:
REPORTED DIZZINESS WHILE DRIVING, HX SEIZURES
Objective Assessment:
AWAKE AND ALERT,COLOR GOOD,
MOVING ALL EXTREMITIES,
OB/GYN History: (if noted below)
SMOKING STATUS for Patients 13 Yrs Old or Older: Current every day smoker
Flowsheet: Yes
Chief Complaint: Vertigo/Dizziness
Priority: CTAS 3/URGENT
Is This a Work Related Injury: No
ESP? No
Facility ESP Status:
NOT ESP Enabled
Is Patient PRESENT? Y
Able to Perform TB & Contagious Respiratory Infection Point of Entry Screen Y
--In the past 3 weeks has the patient:--
Resided in or traveled to an African country: None
Had contact with anyone who has been to a West African country: No
Been in contact with blood or body fluids of a person with Ebola: No
Fever greater than 100.4 F or 38.0 C: N
Is patient currently experiencing any of following in last 7 days:
Fever GREATER than 100.4: N
(38.0 C)
Cough: N
(NOT Related to
Allergy or COPD)
Sore Throat: N
Night Sweats: N
Unexplained Weight Loss: N
Fatigue: N
Body Aches: N
Rash: N
Nasal Congestion (NOT Related to Allergies or Sinus Infections): N
Pt Reports Prior HISTORY of TB or POSITIVE TB Skin Test: N
Close Contact With a Person who has TB: N
Close Contact with ANY Person Having an Influenza-like Illness: N
Travel outside the US in the past 3 weeks: N
TB POINT of ENTRY Screen: NEGATIVE
Contagious Respiratory Infection Point of Entry Screen: NEGATIVE
Temperature: 97.7
TEMP Source: ORAL
Pulse: 66
Respirations: 189
Blood Pressure: 187/89
BP Source: Right Arm
MAP (mm Hg.): 121
O2 Sats: 97
Airway Adjunct: Room air
BILATERAL BLOOD PRESSURES - (If Noted Below) ---------->>
Ht-Ft: 5
Ht-In: 4
Cm: 162.56
How is weight obtained? Stated/Estimated/Broslow
Wt-Lbs: 230
BMI:
39.4
: High
==SEVERE SEPSIS SCREENING==
Temperature: No
WBC results:
No Results past 24 hrs
Heart rate: No
Band results:
No Results past 24 hrs
Respirations: Yes
WBC/Bands: No
If yes to 2 or more of above, proceed to next section: 1
==INFECTION==
==NEW ORGAN DYSFUNCTION within past 48 hours==

Vertigo/Dizziness Assessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1000	Bromley,Robert A., RN	02/17/16	1229	Bromley,Robert A., RN

Presenting Signs & Symptoms: Dizziness, CALLED HIS BOSS TODAY, ON WAY TO WORK AS HE WAS, DRIVING AND TOLD HIM, HE FELT DIZZY AND HADNT , TAKEN HIS NEURONTIN THIS, MORNING. HIS BOSS CALLED , 911 AND PT PULLED OVER. , PT AAOX3, RESP E/U, SKIN , W/D, NO DRIFT NOTED, , PUPILS PERRL, GRIPS EQUAL, AND STRONG BIL.
Initial Onset of Signs & Symptoms: More than 1 Month Ago
Symptoms Constant or Intermittent: Intermittent
Onset of Current Episode: Less Than 1 Hour Ago
Symptom Onset Gradual or Sudden: Gradual
** Recent Head Injury / Freq Fall(s) **
** Current Episode **
Loss of Consciousness: No
Behavior: Appropriate, Calm
** Abbreviated NIH Stroke Scale **

Level of Consciousness: Alert
Questions: Both correct
Commands: Obeys Both
Arm weakness left: No Drift
Arm weakness right: No Drift
Leg weakness left: No Drift
Leg weakness right: No Drift
Pupils PERLA: Yes
NUMBNESS/TINGLING: No
Weakness: No
Hand Grips Equal & Strong: Yes
Leg Strength Equal & Strong: Yes
Balance/Gait: Balanced
Breath Sounds Clear & Equal Bilaterally All Lobes: Yes
Pt on CARDIAC MONITOR: Yes
Cardiac Rhythm: Normal Sinus Rhythm
Does patient have a pacemaker? None
Does Patient Have an Internal Defibrilator? No

Swallow Screening - Assessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1008	Bromley,Robert A., RN	02/17/16	1229	Bromley,Robert A., RN

SWALLOW SAFETY SCREENING ~~~~~~
.
Is Patient CURRENTLY Intubated: N
Acute Stroke/Neurological DX: N
NPO Longer than 48 Hours - NOT R/T Diag Testing: N
Drooling/Difficulty Managing Secretions: N
Wet Voice or Gurgly Breath Sounds: N
Food Residue/Foreign Object in Mouth: N
NEW DX of Head/Neck/Esophageal CA: N
Current DX RLL Pneumonia: N
Facial Weakness / Slurred Speech: N
Anterior Cervical Discectomy w/ Fusion,
CABG or Thoracic Surgery THIS Admit: N
STROKE BOOKLET Given to Pt/Family: N
Is Patient FULLY Awake & Alert: Y
Is Pt Able to Tolerate HOB up 30 Degrees: Y
.
Y
STEP 1: After Drinking 1 tsp (5cc) Water - ANY of the Following Occur: N
STEP 2: After Drinking SIP of Water frm Cup - ANY of the Following Occur: N
STEP 3: After Drinking 3-4 oz of Water - ANY of the Following Occur: N
STEP 4: After Eating 1 Cracker - ANY of the Following Occur: N
Did Pt have Difficulty with ANY of these Steps: N

Vertigo/Dizziness ReAssessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1015	Bromley,Robert A., RN	02/17/16	1601	Bromley,Robert A., RN

Patient Condition Assessment: No Change
Ongoing Signs & Symptoms: Dizziness
Behavior: Appropriate

Level of Consciousness: Alert
Questions: Both correct
Commands: Obeys Both
Arm weakness left: No drift
Arm weakness right: No drift
Leg weakness left: No drift
Leg weakness right: No drift
Pupils PERLA: Yes
NUMBNESS/TINGLING: No
Weakness: No
Hand Grips Equal & Strong: Yes
Leg Strength Equal & Strong: Yes
Balance/Gait: Balanced
Breath Sounds Clear & Equal Bilaterally All Lobes: Yes
Pt on CARDIAC MONITOR: Yes
Cardiac Rhythm: Normal Sinus Rhythm
Skin COLOR: Normal for Ethnicity

Detail Assessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1052	Bromley,Robert A., RN	02/17/16	1057	Bromley,Robert A., RN

Suicide screening: No
Evidence of physical and/or psychological abuse: No
Do you currently think your safety is being threatened by anyone you know: No
Previous Medical History: Yes
Previous Surgeries: Appendectomy, Gallbladder
Enter/Edit home med reconciliation: Y
Nutritional Assessment WDP? Yes
Functional Assessment WDP? Yes
Living arrangements: Lives with others
Tobacco history: Yes
ALCOHOL History: No
Drug use history: No
Are there cultural,religious,language,developmental or behavioral factors
to consider in planning care: No
Any barriers to learning identified: No
Readiness to Learn: Cooperative
Preferred Method of Learning: Demonstration
OB/GYN History: (if noted below)
Do you feel a sense of hopelessness or helplessness that affects the care
: High
ED plan of care
Chief Complaint: Vertigo/Dizziness
Expected outcome of chief complaint: Improved
In the past few days have you been having
I want to ask you if your child attempted suicide
In the past week have you been having
Heart: Yes
: Hypertension, CHF
Respiratory: Yes
: COPD
Neurological: Yes
: Dizzy, Other, FOR A MONTH BEEN TESTED, FOR SEIZURE
GI: No
GU: No

Patient: RUFFINO,JOHN JAMES | Age/Sex: 56/M | Acct No: SM0509454079
ED Provider: Archer,Clark E MD | ED Room: | Unit No: SM00254095

Mental Health: No
Cancer: No
Chronic/Other: Yes
: Hypertension
Comments:
HAS BEEN ON NEURONTIN FOR 4 DAYS FOR "SPELLS"
THAT BEEN GOING ON FOR A MONTH

FAMILY HEALTH HISTORY

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1224	Bromley,Robert A., RN	02/17/16	1224	Bromley,Robert A., RN

Enter/Edit FAMILY HEALTH HISTORY: Y

Medication History

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1224	Bromley,Robert A., RN	02/17/16	1224	Bromley,Robert A., RN

Enter/Edit home med reconciliation: Y

Physical Findings

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1224	Bromley,Robert A., RN	02/17/16	1224	Bromley,Robert A., RN

******** EAR ********
****** NOSE *******
****** THROAT *******

SEVERE SEPSIS SCREENING

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1225	Bromley,Robert A., RN	02/17/16	1225	Bromley,Robert A., RN

Temperature: No
WBC results:
02/17/16 6.6 1015
Heart rate: No
Band results:
No Results past 24 hrs
Respirations: No
WBC/Bands: No
If yes to 2 or more of above, proceed to next section: 0
==INFECTION==
==NEW ORGAN DYSFUNCTION within past 48 hours==

Vertigo/Dizziness ReAssessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1229	Bromley,Robert A., RN	02/17/16	1229	Bromley,Robert A., RN

Patient Condition Assessment: No Change

Vertigo/Dizziness ReAssessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1514	RICHARDS,ABBY, RN	02/17/16	1514	RICHARDS,ABBY, RN

Patient Condition Assessment: No Change

SEVERE SEPSIS SCREENING

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1708	Bromley,Robert A., RN	02/17/16	1708	Bromley,Robert A., RN

Temperature: No
If yes to 2 or more of above, proceed to next section: 0
==INFECTION==
==NEW ORGAN DYSFUNCTION within past 48 hours==

Vertigo/Dizziness ReAssessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1822	Bromley,Robert A., RN	02/17/16	1822	Bromley,Robert A., RN

Patient Condition Assessment: No Change

Vertigo/Dizziness ReAssessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1925	TELEGDY,HAYLEY, RN	02/17/16	1927	TELEGDY,HAYLEY, RN

Patient Condition Assessment: Worsened
Ongoing Signs & Symptoms: DYSPHASIA, RIGHT ARM WEAKNESS
Behavior: Appropriate, Calm
Level of Consciousness: Alert
Questions: Both correct
Commands: Obeys Both
Pupils PERLA: Yes
NUMBNESS/TINGLING: No
Weakness: Yes
Location of Weakness: Hand, Right
Hand Grips Equal & Strong: No
Explain:
RIGHT HAND WEAKER THAN
LEFT
Leg Strength Equal & Strong: Yes
Balance/Gait: Unable to Assess
Breath Sounds Clear & Equal Bilaterally All Lobes: Yes
Pt on CARDIAC MONITOR: Yes
Cardiac Rhythm: Normal Sinus Rhythm
Skin COLOR: Normal for Ethnicity
Skin Temp: Warm, Dry

SEVERE SEPSIS SCREENING

Patient: RUFFINO,JOHN JAMES Age/Sex: 56/M Acct No: SM0509454079
ED Provider: Archer,Clark E MD ED Room: Unit No: SM00254095

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	2111	TELEGDY,HAYLEY, RN	02/17/16	2111	TELEGDY,HAYLEY, RN

Temperature: No
WBC results:
02/17/16 6.6 1015
Heart rate: No
Band results:
No Results past 24 hrs
Respirations: No
WBC/Bands: No
If yes to 2 or more of above, proceed to next section: 0
==INFECTION==
==NEW ORGAN DYSFUNCTION within past 48 hours==

Vertigo/Dizziness ReAssessment

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	2111	TELEGDY,HAYLEY, RN	02/17/16	2114	TELEGDY,HAYLEY, RN

Patient Condition Assessment: No Change
Ongoing Signs & Symptoms: DYSPHASIA, RIGHT SIDED WEAKNESS
Behavior: Appropriate, Calm
Level of Consciousness: Alert
Questions: Both correct
Commands: Obeys Both
Pupils PERLA: Yes
NUMBNESS/TINGLING: No
Weakness: Yes
Location of Weakness: Hand, Right
Hand Grips Equal & Strong: No
Explain:
RIGHT WEAKER THAN LEFT
Balance/Gait: Unable to Assess
Breath Sounds Clear & Equal Bilaterally All Lobes: Yes
Pt on CARDIAC MONITOR: Yes
Cardiac Rhythm: Normal Sinus Rhythm
Skin COLOR: Normal for Ethnicity
Skin Temp: Warm, Dry

Disposition - DC, TX, ADM, LPT

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	2233	TELEGDY,HAYLEY, RN	02/17/16	2234	TELEGDY,HAYLEY, RN

Patient Disposition: Transfer
Disposition Category: Was Stabilized & Transf'd
Assess VITAL SIGNS Now: Yes
Assess PAIN Now: No
EDUCATION Provided: No
IV Infusion Times: No
Discontinue IV: No
FOLEY Discontinue: No
Any ADVERSE REACTION to Meds While in ED: No
SMOKING STATUS for Patients 13 Yrs Old or Older: Current every day smoker
Smoking cessation instruction given to the patient/caregiver: Pt/Caregiver received
Was Pt Treated in FAST TRACK: No
LPMSE
ED plan of care
Chief Complaint: Vertigo/Dizziness
Expected outcome of chief complaint: Improved
Actual outcome of chief complaint: Improved
Temperature: 97.9
TEMP Source: ORAL
Pulse: 69
Respirations: 18
Blood Pressure: 150/85
MAP (mm Hg.): 106
BP Source: Right Arm
O2 Sats: 97
Airway Adjunct: Room air
BILATERAL BLOOD PRESSURES - (If Noted Below) ---------->>
ORTHOSTATIC VITAL SIGNS - (If Noted Below) ---------->>
Glasgow Coma Scale:
.
<< Fetal Heart Rate >>
Days
Days
Reason for Transfer: HIGHER LEVEL OF CARE
Services Required for Transfer: Neurology
Memorandum of Transfer, Documentation of Diagnostics Copied: Yes
Report Given To:
FELICIA SCHUCH, RN
Which Facility:
CENTENNIAL
Via: Ambulance
Which EMS Service: RUTH
Patient Left -->
#1:
#2:
#3:
#4:
#1:
#2:
#3:
#4:
#1:
#2:
#3:
#4:
#1:
#2:
#3:
#4:
==SEVERE SEPSIS SCREENING==
==INFECTION==
==NEW ORGAN DYSFUNCTION within past 48 hours==

TREATMENTS

NEURO Cks w/ Glasgow/Cran Nerv

Occurred	Recorded

Patient: RUFFINO,JOHN JAMES Age/Sex: 56/M Acct No: SM0509454079
ED Provider: Archer,Clark E MD ED Room: Unit No: SM00254095

Date Time User
02/17/16 1000 Bromley,Robert A., RN

GLASGOW COMA SCALE==========
: Y
Best VERBAL: ORIENTED / APPROPRIATE
Best MOTOR: OBEYS Commands
EYE Opening: Open SPONTANEOUSLY
Glasgow Coma Scale TOTAL: 15
Document CRANIAL NERVES &/or NEURO CHECKS on NEXT Pages ^^^^^^>>
CRANIAL NERVES==========
Eye MOVEMENT (III,IV,VI): NORMAL
Gag Reflex (X,XII): NORMAL
Pupil SIZE - L: 3 mm
Pupil RESPONSE - L: BRISK
Pupil SIZE - R: 3 mm
Pupil RESPONSE - R: BRISK
Responsiveness: ALERT
Oriented To: ALERT
Speech/Language: NORMAL
Arm STRENGTH - L: NORMAL POWER
Arm STRENGTH - R: NORMAL POWER
Hand GRIP - L: STRONG
Hand GRIP - R: STRONG
Leg STRENGTH - L: NORMAL POWER
Leg STRENGTH - R: NORMAL POWER
.
Sensation: NORMAL

FLOWSHEET: VITALS

Occurred / Recorded
Date Time User / Date Time User
02/17/16 1011 Bromley,Robert A., RN / 02/17/16 1556 Bromley,Robert A., RN

Pulse: 67
Respirations: 16
Blood Pressure: 158/84
MAP (mm Hg.): 108
O2 Sats: 98
Airway Adjunct: Room air
BILATERAL BLOOD PRESSURES - (If Noted Below) ---------->>
ORTHOSTATIC VITAL SIGNS - (If Noted Below) ---------->>
Ht-Ft: 5
Ht-In: 4
Cm: 162.56
BMI:
39.4
: High
Glasgow Coma Scale:
<< Fetal Heart Rate >>

NEURO Cks w/ Glasgow/Cran Nerv

Occurred / Recorded
Date Time User / Date Time User
02/17/16 1015 Bromley,Robert A., RN / 02/17/16 1604 Bromley,Robert A., RN

GLASGOW COMA SCALE==========
: Y
Best VERBAL: ORIENTED / APPROPRIATE
Best MOTOR: OBEYS Commands
EYE Opening: Open SPONTANEOUSLY
Glasgow Coma Scale TOTAL: 15
Document CRANIAL NERVES &/or NEURO CHECKS on NEXT Pages ^^^^^^>>
CRANIAL NERVES==========
Eye MOVEMENT (III,IV,VI): NORMAL
Gag Reflex (X,XII): NORMAL
Pupil SIZE - L: 3 mm
Pupil RESPONSE - L: BRISK
Pupil SIZE - R: 3 mm
Pupil RESPONSE - R: BRISK
Responsiveness: ALERT
Oriented To: ALERT
Speech/Language: NORMAL
Arm STRENGTH - L: NORMAL POWER
Arm STRENGTH - R: NORMAL POWER
Hand GRIP - L: STRONG
Hand GRIP - R: STRONG
Leg STRENGTH - L: NORMAL POWER
Leg STRENGTH - R: NORMAL POWER
.
Sensation: NORMAL

FLOWSHEET: VITALS

Occurred / Recorded
Date Time User / Date Time User
02/17/16 1026 Bromley,Robert A., RN / 02/17/16 1557 Bromley,Robert A., RN

Pulse: 68
Respirations: 18
Blood Pressure: 148/82
MAP (mm Hg.): 104
O2 Sats: 98
Airway Adjunct: Room air
BILATERAL BLOOD PRESSURES - (If Noted Below) ---------->>
ORTHOSTATIC VITAL SIGNS - (If Noted Below) ---------->>
Ht-Ft: 5
Ht-In: 4
Cm: 162.56
BMI:
39.4
: High
Glasgow Coma Scale:
<< Fetal Heart Rate >>

NEURO Cks w/ Glasgow/Cran Nerv

Occurred / Recorded
Date Time User / Date Time User
02/17/16 1030 Bromley,Robert A., RN / 02/17/16 1606 Bromley,Robert A., RN

GLASGOW COMA SCALE==========
: Y
Best VERBAL: ORIENTED / APPROPRIATE

Patient: RUFFINO,JOHN JAMES Age/Sex: 56/M Acct No: SMO509454079
ED Provider: Archer,Clark E MD ED Room: Unit No: SMO0254095

Best MOTOR: OBEYS Commands
EYE Opening: Open SPONTANEOUSLY
Glasgow Coma Scale TOTAL: 15
Document CRANIAL NERVES &/or NEURO CHECKS on NEXT Pages ^^^^^^>>
CRANIAL NERVES==========
Eye MOVEMENT (III,IV,VI): NORMAL
Gag Reflex (X,XII): NORMAL
Pupil SIZE - L: 3 mm
Pupil RESPONSE - L: BRISK
Pupil SIZE - R: 3 mm
Pupil RESPONSE - R: BRISK
Responsiveness: ALERT
Oriented To: ALERT
Speech/Language: NORMAL
Arm STRENGTH - L: NORMAL POWER
Arm STRENGTH - R: NORMAL POWER
Hand GRIP - L: STRONG
Hand GRIP - R: STRONG
Leg STRENGTH - L: NORMAL POWER
Leg STRENGTH - R: NORMAL POWER
.
Sensation: NORMAL
Comment:
PT UP AND AMBULATED TO RESTROOM S/E GAIT.

FLOWSHEET: VITALS

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1041	Bromley,Robert A., RN	02/17/16	1557	Bromley,Robert A., RN

Pulse: 67
Respirations: 18
Blood Pressure: 154/80
MAP (mm Hg.): 104
02 Sats: 98
Airway Adjunct: Room air
BILATERAL BLOOD PRESSURES - (If Noted Below) ---------->>
ORTHOSTATIC VITAL SIGNS - (If Noted Below) ---------->>
Ht-Ft: 5
Ht-In: 4
Cm: 162.56
BMI:
39.4
: High
Glasgow Coma Scale:
<< Fetal Heart Rate >>

NEURO Cks w/ Glasgow/Cran Nerv

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1045	Bromley,Robert A., RN	02/17/16	1607	Bromley,Robert A., RN

GLASGOW COMA SCALE==========
: Y
Best VERBAL: ORIENTED / APPROPRIATE
Best MOTOR: OBEYS Commands
EYE Opening: Open SPONTANEOUSLY
Glasgow Coma Scale TOTAL: 15
Document CRANIAL NERVES &/or NEURO CHECKS on NEXT Pages ^^^^^^>>
CRANIAL NERVES==========
Eye MOVEMENT (III,IV,VI): NORMAL
Gag Reflex (X,XII): NORMAL
Pupil SIZE - L: 3 mm
Pupil RESPONSE - L: BRISK
Pupil SIZE - R: 3 mm
Pupil RESPONSE - R: BRISK
Responsiveness: ALERT
Oriented To: ALERT
Speech/Language: NORMAL
Arm STRENGTH - L: NORMAL POWER
Arm STRENGTH - R: NORMAL POWER
Hand GRIP - L: STRONG
Hand GRIP - R: STRONG
Leg STRENGTH - L: NORMAL POWER
Leg STRENGTH - R: NORMAL POWER
.
Comment:
PT ON STRETCHER IV PATENT. PT AAOX3, RESP E/U
SKIN W/D.

FLOWSHEET: VITALS

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1050	Bromley,Robert A., RN	02/17/16	1051	Bromley,Robert A., RN

Pulse: 63
Respirations: 16
Blood Pressure: 127/79
MAP (mm Hg.): 95
02 Sats: 96
Airway Adjunct: Room air
BILATERAL BLOOD PRESSURES - (If Noted Below) ---------->>
ORTHOSTATIC VITAL SIGNS - (If Noted Below) ---------->>
Ht-Ft: 5
Ht-In: 4
Cm: 162.56
BMI:
39.4
: High
Glasgow Coma Scale:
<< Fetal Heart Rate >>

FLOWSHEET: VITALS

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1056	Bromley,Robert A., RN	02/17/16	1558	Bromley,Robert A., RN

Pulse: 68
Respirations: 18
Blood Pressure: 154/79
MAP (mm Hg.): 104
02 Sats: 98

Patient: RUFFINO,JOHN JAMES Age/Sex: 56/M Acct No: SMC509454079
ED Provider: Archer,Clark E MD ED Room: Unit No: SM00254095

Airway Adjunct: Room air
BILATERAL BLOOD PRESSURES - (If Noted Below) ----------->>
ORTHOSTATIC VITAL SIGNS - (If Noted Below) ----------->>
Ht-Ft: 5
Ht-In: 4
Cm: 162.56
BMI:
39.4
: High
Glasgow Coma Scale:
<< Fetal Heart Rate >>

NEURO Cks w/ Glasgow/Cran Nerv

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1100	Bromley,Robert A., RN	02/17/16	1608	Bromley,Robert A., RN

GLASGOW COMA SCALE==========
: Y
Best VERBAL: ORIENTED / APPROPRIATE
Best MOTOR: OBEYS Commands
EYE Opening: Open SPONTANEOUSLY
Glasgow Coma Scale TOTAL: 15
Document CRANIAL NERVES &/or NEURO CHECKS on NEXT Pages ~~~~~~>>
CRANIAL NERVES==========
Eye MOVEMENT (III,IV,VI): NORMAL
Gag Reflex (X,XII): NORMAL
Pupil SIZE - L: 3 mm
Pupil RESPONSE - L: BRISK
Pupil SIZE - R: 3 mm
Pupil RESPONSE - R: BRISK
Responsiveness: ALERT
Oriented To: ALERT
Speech/Language: NORMAL
Arm STRENGTH - L: NORMAL POWER
Arm STRENGTH - R: NORMAL POWER
Hand GRIP - L: STRONG
Hand GRIP - R: STRONG
Leg STRENGTH - L: NORMAL POWER
Leg STRENGTH - R: NORMAL POWER
.
Sensation: NORMAL

NEURO Cks w/ Glasgow/Cran Nerv

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1200	Bromley,Robert A., RN	02/17/16	1702	Bromley,Robert A., RN

GLASGOW COMA SCALE==========
: Y
Best VERBAL: ORIENTED / APPROPRIATE
Best MOTOR: OBEYS Commands
EYE Opening: Open SPONTANEOUSLY
Glasgow Coma Scale TOTAL: 15
Document CRANIAL NERVES &/or NEURO CHECKS on NEXT Pages ~~~~~~>>
CRANIAL NERVES==========
Eye MOVEMENT (III,IV,VI): NORMAL
Gag Reflex (X,XII): NORMAL
Pupil SIZE - L: 3 mm
Pupil RESPONSE - L: BRISK
Pupil SIZE - R: 3 mm
Pupil RESPONSE - R: BRISK
Responsiveness: ALERT
Oriented To: ALERT
Speech/Language: NORMAL
Arm STRENGTH - L: NORMAL POWER
Arm STRENGTH - R: NORMAL POWER
Hand GRIP - L: STRONG
Hand GRIP - R: STRONG
Leg STRENGTH - L: NORMAL POWER
Leg STRENGTH - R: NORMAL POWER
.
Sensation: NORMAL

FLOWSHEET: VITALS

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1222	Bromley,Robert A., RN	02/17/16	1222	Bromley,Robert A., RN

Pulse: 56
Respirations: 16
Blood Pressure: 150/79
MAP (mm Hg.): 102
02 Sats: 97
Airway Adjunct: Room air
BILATERAL BLOOD PRESSURES - (If Noted Below) ----------->>
ORTHOSTATIC VITAL SIGNS - (If Noted Below) ----------->>
Ht-Ft: 5
Ht-In: 4
Cm: 162.56
BMI:
39.4
: High
Glasgow Coma Scale:
<< Fetal Heart Rate >>

IV: SALINE LOCK - Tx & ORDER

Occurred Date	Time	User	Recorded Date	Time	User
02/17/16	1222	Bromley,Robert A., RN	02/17/16	1223	Bromley,Robert A., RN

Time #1 IV Started: 1030
Date: 02/17/16
Where/Who Started:
TONY
Size (Gauge): #20
Type of Catheter: Single Lumen
# of Attempts: 1
IV Site: ACF, Left
#1:
#2:
#3:

STONECREST MEDICAL CENTER
MEDICAL IMAGING
200 STONECREST BLVD
SMYRNA, TN 37167
PHONE #: 615-768-2370
FAX #:

Name: RUFFINO,JOHN JAMES
Phys: Archer,Clark E MD
DOB: 06/12/1959 Age: 56 Sex: M
Acct: SM0509454079 Loc: SM.ER05 A
Exam Date: 02/17/2016 Status: ADM IN
Radiology No:
Unit No: SM00254095

EXAMS:	Reason:	CPT:
000822509 CT ANGIO HEAD W/WO CON	NEU - Neurological Deficit	70496

CTA head with/without contrast

Comparison: CT head at 1029 hours.

History: Dizziness.

Technique: Noncontrast CT brain performed earlier today. Subsequently helical images obtained through the brain following dynamic intravenous administration of 100 cc Isovue-370 contrast. Image postprocessing including MIPs and3D reconstructions performed on independent workstation.

CTA head: There is abrupt, complete occlusion of the LEFT MCA proximal M2 segment. There is a paucity of vascularity in the LEFT MCA territory. The other major cerebral vessels are widely patent. The basilar artery and its bifurcation are unremarkable. The anterior communicating artery is patent and the posterior communicating arteries are not visualized. The dural venous sinuses are patent. No aneurysm, vascular malformation, or abnormal enhancement..

Impression: There is complete occlusion of the proximal LEFT MCA M2 segment.

Case discussed with Dr. Clark E Archer, MD at 2/17/2016 3:17 PM.

Result Code: (CR) CRITICAL RESULT

CTA neck with and without contrast

Comparison: None available.

History: Right-sided weakness and slurred speech.

Technique: Noncontrast localizer images obtained. Subsequently, helical images obtained from superior mediastinum through skull base following dynamic intravenous administration 100 cc Isovue-370 contrast. Image postprocessing including MIPs and multiplanar 3D reconstructions.

Nonvascular findings: No acute abnormality.

Arch: Normal caliber and configuration. No high-grade stenosis of the brachiocephalic vessels.

Right Carotid: Widely patent with mild calcific plaque proximal ICA.

STONECREST MEDICAL CENTER
MEDICAL IMAGING
200 STONECREST BLVD
SMYRNA, TN 37167
PHONE #: 615-768-2370
FAX #:

Name: RUFFINO,JOHN JAMES
Phys: Archer,Clark E MD
DOB: 06/12/1959 Age: 56 Sex: M
Acct: SM0509454079 Loc: SM.ER05 A
Exam Date: 02/17/2016 Status: ADM IN
Radiology No:
Unit No: SM00254095

EXAMS:	Reason:	CPT:
000822509 CT ANGIO HEAD W/WO CON	NEU - Neurological Deficit	70496

<Continued>

Left Carotid: Widely patent with minimal calcific plaque at the bifurcation.

Right Vertebral: Widely patent, codominant.

Left Vertebral: Widely patent, codominant.

Impression: No occlusion or hemodynamic stenosis.. .

** Electronically Signed by Keith R. Parker MD on 02/17/2016 at 1518 **
Reported and signed by: Keith R. Parker, MD

CC: NO PRIMARY OR FAMILY PHYSICIAN; SELF REFERRED

Technologist: Chad Robinette,ARRT(R,CT); Kiwaski Vaughn
Transcribed Date/Time: 02/17/2016 (1455)
CTDI:21.70 DLP:884.37
Electronic Signature Date/Time: 02/17/2016 (1518)
Orig. Print D/T: S: 02/17/2016 (1520)

STONECREST MEDICAL CENTER
MEDICAL IMAGING
200 STONECREST BLVD
SMYRNA, TN 37167
PHONE #: 615-768-2370
FAX #:

Name: RUFFINO,JOHN JAMES
Phys: Raad,Osman K DO
DOB: 06/12/1959 Age: 56 Sex: M
Acct: SM0509454079 Loc: SM.ER
Exam Date: 02/17/2016 Status: REG ER
Radiology No:
Unit No: SM00254095

EXAMS:	Reason:	CPT:
000822440 CT HEAD W/O CONTRAST	dizzy	70450

CT head without contrast

Comparison: None available.

Indication: Dizziness.

Technique: Axial images obtained from skull base through calvarium without contrast.

Findings:

Cerebrum: There is age-appropriate atrophy.. There is no intracranial hemorrhage or midline shift. No periventricular deep white matter changes..

Posterior fossa: No hemorrhage. The basilar cisterns are maintained. There is a prominent cisterna magna. There is calcific plaque of the distal LEFT vertebral artery..

Ventricular system: Normal.

Calvarium, sinuses, and skull base: Unremarkable.

The internal auditory canals are normal.

Impression: There is no acute intracranial abnormality. Otherwise as above..

** Electronically Signed by Keith R. Parker MD on 02/17/2016 at 1035 **
Reported and signed by: Keith R. Parker, MD

CC: Mark NP Reinhardt

Technologist: Chad Robinette,ARRT(R,CT)

Transcribed Date/Time: 02/17/2016 (1026)
CTDI:50.75 DLP:817.20
Electronic Signature Date/Time: 02/17/2016 (1035)
Orig Print D/T: S: 02/17/2016 (1037)

STONECREST MEDICAL CENTER
MEDICAL IMAGING
200 STONECREST BLVD
SMYRNA, TN 37167
PHONE #: 615-768-2370
FAX #:

Name: RUFFINO,JOHN
Phys: Raad,Osman K DO
DOB: 06/12/1959 Age: 56 Sex: M
Acct: SM0509454079 Loc: SM.ER
Exam Date: 02/17/2016 Status: PRE ER
Radiology No:
Unit No: SM00254095

EXAMS:	Reason:	CPT:
000822441 XR CHEST 1 VIEW PORT	CP - Chest Pain	71010

AP PORTABLE CXR 10:15 AM 2/17/2016

HISTORY: CP - Chest Pain

COMPARISON: none

FINDINGS: The heart size is normal. The lungs are clear. The inspiration is limited.

IMPRESSION: Slightly limited by suboptimal inspiration, but no abnormality is demonstrated.

** Electronically Signed by Jack R. Baker MD on 02/17/2016 at 1015 **
Reported and signed by: Jack R. Baker, MD

CC: Mark NP Reinhardt

Technologist: Morgan Holmes, RT(R)

Transcribed Date/Time: 02/17/2016 (1015)
Electronic Signature Date/Time: 02/17/2016 (1015)
Orig Print D/T: S: 02/17/2016 (1017)
BATCH NO: N/A

PRINTED BY:bpa9869 DATE 1/5/2017

Patient: Ruffino, John Medical Record Number: M001949828

Facility: Centennial Medical Center Phone Number: 615-695-8700

Address: 2300 Patterson St City/State: Nashville, TN Zip: 37203

CERTIFICATION OF MEDICAL RECORDS

To the best of my knowledge, the copied documents, records and other items enclosed are true and correct copies of all original records identified and described in the subpoena duces tecum, patient authorization, or court order made by or at the direction of the custodian of records. The original records were prepared in the ordinary course of the facility's regularly conducted business at or near the time of the act, condition, or event by persons with knowledge of the facts recorded, and the records have been maintained in the ordinary course of the facility's regularly conducted business according to all confidentiality and security requirements of law. This certification is given by the custodian of records instead of the custodian's personal appearance.

We are not aware of any omissions; however, due to the timing of this request it is possible that a portion of the medical record may be incomplete and/or preliminary at this time.

The Custodian hereby certifies the amount charged for production of the requested records is reasonable within the standards of the community and other similarly situated Hospitals.

The recipient of these records agrees to maintain their confidentiality and permit further disclosure only as authorized by law.

Select Only One:

- ☐ The complete records consisting of 923 pages.
- ☐ The complete records for the time period beginning _____ and ending _____ consists of _____ pages.
- ☐ The copied records consist of _____ pages per your request for specific portions of the medical record.
- ☐ The copied records consist of _____ pages. They are incomplete in the following: _____

CERTIFICATION OF NO RECORDS

- ☐ A thorough search of requested information carried out under my direction and control revealed that this facility does not have the records described in the patient authorization or the subpoena duces tecum.

DECLARATION OF CUSTODIAN OF RECORDS

I, Denise Danitz, am the duly authorized Custodian of Records of the above named facility. I am familiar with the mode of preparation of, and have the authority to certify, the facility record. I declare under penalty of perjury under the laws of the State of Tennessee, County of Davidson that the foregoing is true and correct.

Signature Date 10/6/17

****

Subscribed and sworn to me, a notary public in and for said county, this _____ Day of _____ 20___.

_____
Notary Public
My commission expires: _____

(Seal)

In states where a Notary is not required, this form will only include signature and date of the medical record custodian.

CENTENNIAL MEDICAL CENTER
2300 Patterson Street
Nashville, TN 37203

****HISTORY AND PHYSICAL****

ROOM: M.NS03-A
STATUS: ADM IN
PATIENT: RUFFINO,JOHN JAMES
MR#: M001949828
ACC#: M00158587645
DOB: 06/12/59
PHYSICIAN: Akanbi,Olabisi O MD

DATE OF ADMISSION: 02/17/16

DATE OF ADMISSION:
February 18, 2016

The patient was transferred from StoneCrest.

The patient was then seen by me on February 18, 2016.

CHIEF COMPLAINT:
The patient was transferred from StoneCrest where stroke was diagnosed.

HISTORY OF PRESENT ILLNESS:
The patient is a 56-year-old Caucasian male with medical history significant for hypertension and hypercholesterolemia, who presented to StoneCrest ED on account of dizziness and slurred speech with facial muscle weakness as well. This was started around 8 p.m. yesterday morning. The patient is, however, a poor historian, so history was obtained by chart review and also from wife. The patient stated that he has been having these acute events with speech difficulty and facial weakness of unknown for the past 1 month. He has had about 3 episodes so far, which really lasted for about 3 to 5 minutes and resolved completely afterwards. The patient was presented to the StoneCrest medical facility way way after the thrombolytic window and at that time, CT head was done, which did not show any intracranial abnormalities and also a CTA was done, which did not show any significant stenosis. The patient at presentation was still having the right facial weakness and droop wit slurred speech with some expressive aphasia. The history, patient woke up with above listed symptoms in the morning. At Lebanon University Medical Center, he was worked up extensively with MRI brain and MRA of the brain as well with negative findings. He was given aspirin at that time and was treated for possible seizures with gabapentin.

The patient was subsequently transferred to Centennial Medical Center, it has to be reviewed by the neurologist over here.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Hypercholesterolemia.

PAST SURGICAL HISTORY:
Noncontributory.

FAMILY HISTORY:
Noncontributory, patient is a poor historian.

SOCIAL HISTORY:
The patient says he does not smoke or drink alcohol, use illicit drugs.

REVIEW OF SYSTEMS:
The 12-point review of system done was negative except for the findings as stated in the history of present illness. No more details could be collected due to the patient's aphasia.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature is 97.7, pulse rate is 58, respirations are 18, blood pressure is 133/77 with O2 sat of 97.
GENERAL: Alert and oriented x3, not in any cardiopulmonary distress, lying in bed calmly.
HEENT: No pallor, anicteric, or cyanosed. No oropharyngeal exudates. Pupils were reactive to light and accommodation. Extraocular muscles are intact.
NECK: No neck pain. No JVD.
CARDIOVASCULAR: S1, S2, no murmur.
RESPIRATORY: Intact. Clear to auscultation bilaterally.
MUSCULOSKELETAL: The patient has right-sided weakness, also facial droop on the face. The patient favors use on the left hand more than the right.
NEUROLOGIC: The patient is alert, awake, and oriented x3, has some language difficulties and dysarthric especially about his problems. Pupils were reactive to light and accomodation. The patient has facial weakness on the right side of the face and tongue is still midline. Muscle bulk and tone are still fine and has some mild weakness on the proximal and distal right muscles. Gait could not be assessed at this time.

LABORATORY DATA:
1. WBC 6.6, hemoglobin is 14.4, hematocrit is 41.7 with platelets of 226. Troponin was 0.01. CMP: Sodium is 137, potassium is 3.7, chloride is 100, bicarb is 25, BUN 17, and creatinine is 1.1 with glucose of 121, INR is 0.9.
2. Chest x-ray shows no abnormality.
3. CT head shows no acute intracranial abnormality.
4. CTA head shows no signs of stenosis.
5. UA was negative.
6. UDS was negative.

SUMMARY:
The patient is a 56-year-old Caucasian male, admitted on account of stroke.

PLAN:
1. Presently, the patient will be admitted for conservative management as patient has passed the window for thrombolytics. We will go ahead and get an MRI of the brain to access for any acute ischemic changes.
2. We are going to get neurologic consult for review.
3. We are going to place the patient on IV normal saline to run at 125 mL an hour.
4. We are going to allow for permissive hypertension for now to encourage

cerebral perfussion.
5. We are going to wake patient up for getting A1c, lipid panel, also monitor his CBC.
6. We are going to get swallow study in patient as well.
7. We are going to physical therapy, occupational and speech therapy as well.
8. Deep venous thrombosis prophylaxis as Lovenox.
9. Code status is FULL CODE.

DD:02/18/2016 08:40:12 DT:02/18/2016 11:31:03 SGSNASHHSC;Job#2899500
Authenticated and Edited by Olabisi O Akanbi, MD On 2/21/16 10:20:44 AM

Olabisi O Akanbi, MD

REPORT ID: 0219-0094

Electronically Signed by Olabisi O Akanbi, MD on 02/21/16 at 1025

PT: RUFFINO,JOHN JAMES UNIT: M001949828 ACCT: M00158587645

CENTENNIAL MEDICAL CENTER (COCCT)
Neurology Consultation Note
REPORT#:0218-0236 REPORT STATUS: Signed
DATE:02/18/16 TIME: 0829

PATIENT: RUFFINO,JOHN JAMES UNIT #: M001949828
ACCOUNT#: M00158587645 ROOM/BED: M.NS03-A
DOB: 06/12/59 AGE: 56 SEX: M ATTEND: Nottidge, Michael E., MD
ADM DT: 02/17/16 AUTHOR:
Jarquin-Valdivia,Adrian A MD
REP SRV DT: 02/18/16 REP SRV TM: 0829
* ALL edits or amendments must be made on the electronic/computer document *

History of Present Illness

Requesting clinician: Dr Paranjepe
Reason for consult:
stroke
Chief complaint:
stroke
HPI:
The patient is a 56 year-old right-handed, married, truck driver, smoker, man.
Since around December 2015, he has been having episodes of right hemmiparesis and aphasia/dysarthria, the episodes would be self-limited, and last for about 10-15 minutes. The episodes have been stereotypical.
The night before yesterday, he went to bed in usual state of health, in the morning yesterday, he got ready to go to work at that time the wife noted that the patient was not speaking normal and that he was confused. At about 08:00 hrs, while at work, he had increased right-sided weakness and aphasia/dysarthria.

MH: obese, smoker, hypertension, dyslipidemia,
SH: chole
SocH: +smoker, no alcohol, no illicits, employed,

History

Past History

Family history:
MOTHER
Family History: Cancer, Onset: 60+.
FATHER
Family History: Cancer, Onset: 60+.
Relation not specified for:
Family History: Unremarkable

Medications:

Home Medications:

Medication	Dose/Rte/Freq	Days	Qty	Entered	Last Reviewed
Lisinopril (Zestril) Strength: (Unknown Strength) TAB	40 MG PO DAILY			02/17/16 2315	02/18/16 1138
Tamsulosin (Flomax) Strength: (Unknown Strength) CAP	0.4 MG PO DAILY			02/17/16 2316	02/18/16 1138
Gabapentin (Neurontin) Strength: (Unknown Strength) CAP	300 MG PO DAILY 2100			02/17/16 2317	02/18/16 1138
Aspirin Strength: 81 MG TAB	81 MG PO DAILY			02/17/16 2319	02/17/16 2319
Atorvastatin (Lipitor) Strength: (Unknown Strength) TAB	10 MG PO DAILY			02/17/16 2320	02/18/16 1138
Ibuprofen (Motrin) Strength: 800 MG TAB	800 MG PO TID			02/18/16 1138	02/18/16 1138

Current Hospital Medications:

Anti-Infective Agents

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Minocycline HCl (MINOCYCLINE HCL)	200 MG	DAILY PO	02/18 1430 02/21 0901	CAN	
Minocycline HCl (MINOCYCLINE HCL)	200 MG	DAILY PO	02/18 1209 02/22 0901	CKD	02/18 1305

Autonomic Drugs

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Phenylephrine HCl (PHENYLEPHRINE HCL) Sodium Chloride (SODIUM CHLORIDE 0.9%)	30 MG 250 ML	ASDIR PRN IV	02/18 1930 04/18 1931	CKD	
Phenylephrine HCl (PHENYLEPHRINE SYRINGE 0.1MG/ML)	0	.STK-MED ONE IV	02/18 1703	DC	02/18 1715

Blood Formation,Coagulation &

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Enoxaparin Sodium (LOVENOX)	40 MG	Q24H SUBQ	02/18 0600 04/18 0601	AC	02/18 0555

Cardiovascular Drugs

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Lisinopril (PRINIVIL)	40 MG	DAILY PO	02/19 0900 04/19 0901	AC	
Tamsulosin HCl (FLOMAX 0.4 MG)	0.4 MG	DAILY PO	02/19 0900 04/19 0901	AC	
Atorvastatin Calcium (LIPITOR)	40 MG	BEDTIME PO	02/18 2100 04/18 2101	AC	
Lidocaine HCl (LIDOCAINE HCL 2%)	0	.STK-MED ONE INJ	02/18 1827	DC	02/18 1921
Atorvastatin Calcium (LIPITOR)	10 MG	DAILY PO	02/18 1219 04/18 1220	CAN	

Central Nervous System Agents

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Aspirin (ASPIRIN)	325 MG	DAILY PO	02/18 1100 04/18 1101	AC	02/18 1044
Aspirin (ASPIRIN)	300 MG	DAILY RECTAL	02/18 0900 04/18 0901	DC	

Diagnostic Agents

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Iopamidol (ISOVUE-370)	40 ML	.STK-MED ONE IV	02/18 1254 02/18 1255	DC	02/18 1254

Electrolytic, Caloric, And Wat

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Sodium Chloride (SODIUM CHLORIDE 0.9%)	500 ML	BOLUS ONE IV	02/18 1207 02/18 1236	DC	02/18 1305
Sodium Chloride (SODIUM CHLORIDE 0.9%)	1,000 ML	.Q8H IV	02/18 0304 04/18 0305	AC	02/18 1922

Gastrointestinal Drugs

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin

Docusate Sodium (DOCUSATE SODIUM)	100 MG	BID PO	02/18 1210 04/18 2101	AC	02/18 1306
Fish Oil (FISH OIL CONCENTRATE)	1,000 MG	DAILY PO	02/18 1209 04/19 0901	CKD	02/18 1306
Famotidine (PEPCID)	20 MG	BID PO	02/18 0900 04/18 0901	AC	02/18 1044

Vitamins

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Cholecalciferol (VITAMIN D3)	1,000 INTL.UNITS	DAILY PO	02/18 1209 04/19 0901	CKD	02/18 1306

Allergies:
Coded Allergies:
No Known Drug Intolerances (. 02/17/16)

Review of Systems
Unable to obtain due to:
aphasia

Objective

Physical Exam
VS:
Last Documented:

	Result	Date Time
B/P	167/79	02/18 1829
Pulse Ox	99	02/18 1829
Pulse	70	02/18 1829
Resp	18	02/18 1829
Temp	37.2	02/18 1700
O2 Delivery	ROOM AIR	02/18 1545

Date: Time:
Delirious/Non-Delirious: Total Score:
Target RASS: []

Medications:
Current Home Medications
Lisinopril (Zestril) 40 MG PO DAILY
Tamsulosin (Flomax) 0.4 MG PO DAILY
Gabapentin (Neurontin) 300 MG PO DAILY 2100
Aspirin 81 MG PO DAILY
Atorvastatin (Lipitor) 10 MG PO DAILY
Ibuprofen (Motrin) 800 MG PO TID

Active Meds + DC'd Last 24 Hrs
Lisinopril 40 MG DAILY PO
Tamsulosin HCl 0.4 MG DAILY PO
Atorvastatin Calcium 40 MG BEDTIME PO
Phenylephrine HCl 30 MG ASDIR PRN IV (CKD)
Sodium Chloride 250 ML
Lidocaine HCl 0 .STK-MED ONE INJ (DC)
Phenylephrine HCl 0 .STK-MED ONE IV (DC)
Minocycline HCl 200 MG DAILY PO (CAN)
Iopamidol 40 ML .STK-MED ONE IV (DC)
Atorvastatin Calcium 10 MG DAILY PO (CAN)
Docusate Sodium 100 MG BID PO
Cholecalciferol 1,000 INTL.UNITS DAILY PO (CKD)
Fish Oil 1,000 MG DAILY PO (CKD)
Minocycline HCl 200 MG DAILY PO (CKD)
Sodium Chloride 500 ML BOLUS ONE IV (DC)
Aspirin 325 MG DAILY PO
Aspirin 300 MG DAILY RECTAL (DC)
Famotidine 20 MG BID PO
Enoxaparin Sodium 40 MG Q24H SUBQ
Sodium Chloride 1,000 ML .Q8H IV

General appearance: altered mental state, obese, alert, awake, lying in bed, no respiratory distress
Head/Eyes: clear cornea, normocephalic, pupils are 2 mm CRR no nystagmus
ENT: normal nose
Neck: supple/no meningismus, no masses or swelling, trachea non-displaced
Cardiovascular: regular rate and rhythm
Respiratory: symmetric chest expansion, no distress
Abdomen: soft, no distention
Extremities: normal inspection, no edema
Musculoskeletal: normal inspection

Skin: dry, intact

Speech
Speech: global aphasia, dysarthric, dystusia, speech apraxia

Mental Status
LOC: alert
Mental status: cooperates

Glasgow
Glasgow Coma Score

Glasgow Coma Score	Response	Value
Glasgow eyes:	eyes open spontaneously	4
Glasgow speech:	incomprehensible sounds	2
Glasgow motor:	obeys commands	6
Total		12

Cranial Nerves
Cranial nerves:
Abnormal: VII.

Motor Testing
Motor testing 1:
Normal: bulk.
Motor Testing 2:
No asterixis, No dystonia, No fasciculations, No myoclonus, No myotonia, No tremor

Cerebellar Test
Cerebellar test:
Normal L finger/nose/finger
Nystagmus: absent

Reflexes
Tendon reflexes:
1+: R Bicep, L Bicep, R Patella, L Patella.

NIH Stroke Scale
NIH Stroke Scale

NIH Stroke Scale	Response	Value

Level of consciousness:	Alert, keenly responsive	0
Ask Month & Age:	Answers one correctly	1
Open/close eyes/hand grip	Performs one correctly	1
Horizontal EO movements	Partial paresis	1
Visual fields:	Partial hemianopsia	1
Facial palsy:	Partial facial paralysis	2
Lt arm motor drift (10s)	No drift	0
Rt motor arm drift (10s)	Drift; effort yet touches	2
Lt leg motor drift (5s)	No drift	0
Rt leg motor drift (5s)	Drift; does not touch bed	1
Limb ataxia FNF/heel-shin (F-N/H-S)	Absent	0
Sensation (arms/legs/face):	Mild, aware yet dulled	1
Language aphasia:	Severe, fragmentary	2
Dysarthria:	Slurring, intelligible	1
Extinction/inattention:	No abnormality	0
Total		13

Results

Findings/Data:

Laboratory Tests

	02/18 0406	02/18 0455
Chemistry		
Sodium (135 - 146 MEQ/L)		141
Potassium (3.5 - 5.3 MEQ/L)		3.5
Chloride (98 - 107 MEQ/L)		108 H
Carbon Dioxide (20 - 33 MEQ/L)		28
Anion Gap (4 - 14)		5
BUN (7 - 25 MG/DL)		13
Creatinine (0.6 - 1.3 MG/DL)		0.9
GFR Calculation		>90
BUN/Creatinine Ratio (6 - 25 RATIO)		13.9
Glucose (70 - 115 mg/dl)		96
Calcium (8.5 - 10.1 MG/DL)		8.1 L
Triglycerides (<150 MG/DL)	75	
Cholesterol (0 - 200 MG/DL)	127	
LDL Cholesterol (0 - 130 MG/DL)	81	
VLDL Cholesterol (8 - 62 MG/DL)	15	
Non-HDL Cholesterol (mg/dL)	96	
HDL Cholesterol (>40 MG/DL)	31 L	

LDL/HDL Ratio	2.6	
Cholesterol/HDL Ratio (RATIO)	4.1	

Laboratory Tests

	02/18 0455
Hematology	
WBC (3.9 - 10.6 K/mm3)	7.9
RBC (4.50 - 5.30 M/mm3)	4.64
Hgb (13.0 - 17.0 GM/DL)	13.7
Hct (37.0 - 49.0 %)	40.4
MCV (80.0 - 100.0 fl)	87.0
MCH (27.0 - 35.0 pg)	29.6
MCHC (31.0 - 37.0 g/dl)	34.0
RDW (11.5 - 14.5 %)	12.3
RDW Std Deviation (36.5 - 45.9 %)	37.6
Plt Count (150 - 450 k/cumm)	217
MPV (6.8 - 10.2 fl)	8.9

Radiology Data:
Recent Impressions:
COMPUTERIZED TOMOGRAPHY - CT CEREB PERF ANALYSIS 00042T 02/18 1320
*** Report Impression - Status: SIGNED Entered: 02/18/2016 1355

Impression: Decreased perfusion throughout the left middle cerebral artery distribution of the parasylvian left temporal, parietal and frontal lobes without evidence of ischemia at this time.

Impression By: DR.LASGR - Gregory L. Lassiter, MD

Results: labs reviewed, CT personally reviewed, rhythm personally rev'd

Diagnosis, Assessment & Plan

Free Text A&P:
He has been having crescendo stereotypical TIAs.
Now with left hemiparesis, aphasia.
HOB down, bolus of IV NS and he had some clinical improvement.

Sent for CTP, showing large penumbra ischemica.

Arranged transfer to NeuroICU for therapeutic hypertension, to try to perfuse and save the penumbra.
Minocycline given PO today.
Place on IV Neo.
Keep HOB down flat.
Aggresive IV NS hydration/resuscitation. Goal SBP 170-19 torr.

He is >6 hours from onset of symptoms, and at this time, he is over 24 hours from onset of symptoms.

Discussed at length with wife, her questions answerwed
Discussed with Dr Paranjepe and Dr Nottidge.
By POCUS the LV EF >50%.
Get MRI brain tomorrow.

Stroke Core measures.

Place on cardiac telemetry to screen for intermittent atrial fibrillation.
Optimize 2ry stroke prevention: decrease salt intake to <4 grams/day; keep an active life style with scheduled 30-60 minutes a day of exercise. Aim at a normal BMI. Consider consult to dietitian/nutritionist. Include fish in diet (http://tinyurl.com/strokeandfish).
From the secondary stroke prevention perspective, consider adding a thiazide and lisinopril as the primary hypertension management medication regimen, and aim for SBP circa 120 torr (following JNC8 guidelines goals; and PROGRESS, 2001). He/she needs 1 (one) antiplatelet agent, indefinitely.
Continue DVT prophylaxis while hospitalized. Provide stroke education, printed AND verbal; teach FAST scale.
Encourage patient (and family) to d/c smoking. Please, emphasize the importance of this recommendation. (http://tinyurl.com/stoppingtobacco) Screen for obstructive sleep apnea, and schedule sleep clinic evaluation if OSA is suspected. (http://tinyurl.com/strokeosa)
Screen for depression, and treat accordingly.
If this patient drive motor vehicles, I advise to not do so for at least 1-2 weeks, and until a physician releases to patient to driving again.
A FAST educational video for patients and families can be accessed at: tinyurl.com/fastscale
cc76
Orders:

Procedure	Date/time	Status
IV Drip Titrate	02/18 1842	Active

Foley Removal (Nurse Driven)	02/18 1810	Active
Order Set Tracking	02/18 1210	Active
SWALLOW Screening (Nursing)	02/18 1210	Active
Sequential Compression Device	02/18 1210	Active
Pulse Oximetry (Order)	02/18 1210	Active
RT: Oxygen Therapy	02/18 1210	Active
Neurological Check	02/18 1210	Active
Notify MD: VS Parameters	02/18 1210	Active
Education - STROKE Diagnosis	02/18 1210	Active
Education, Smoking Cessation	02/18 1210	Active
Education, DX, TX, Proc Tests	02/18 1210	Active
Potential Stroke Core Measure	02/18 1210	Active
Telemetry Monitor	02/18 1210	Active
Anticoagulant Monitor	02/18 1210	Active
MRI BRAIN W/O CONTRAST 70551	02/18 1210	Active
Foley Catheter Insert	02/18 UNK	Active
Activity Order	02/18 UNK	Active
CT CEREB PERF ANALYSIS 00042T	02/18 UNK	Complete

Electronically Signed by Jarquin-Valdivia,Adrian A MD on 02/18/16 at 2021

RPT #: 0218-0236
END OF REPORT

CENTENNIAL MEDICAL CENTER (COCCT)
Neurology Progress Note
REPORT#:0226-1136 REPORT STATUS: Signed
DATE:02/26/16 TIME: 1851

PATIENT: RUFFINO,JOHN JAMES UNIT #: M001949828
ACCOUNT#: M00158587645 ROOM/BED: M.7131-A
DOB: 06/12/59 AGE: 56 SEX: M ATTEND: Sharifi,Naim MD
ADM DT: 02/17/16 AUTHOR:
Jarquin-Valdivia,Adrian A MD
REP SRV DT: 02/26/16 REP SRV TM: 1851
* ALL edits or amendments must be made on the electronic/computer document *

Subjective

Subjective:
can cary a simple conversation
no d/v/n
ambulating, without aggravation of language/speech nor motor function.

Objective

Physical Exam

VS:
Last Documented:

	Result	Date Time
B/P	118/70	02/26 1429
Temp	36.5	02/26 1429
Pulse	62	02/26 1429
Resp	18	02/26 1429
Pulse Ox	94	02/26 1158
O2 Delivery	ROOM AIR	02/26 1158

Date: 02/25/16 Time: 2043
Delirious/Non-Delirious: NO DELIRIUM Total Score: 0 = ALERT AND CALM
Target RASS: []

General appearance: alert, awake, no respiratory distress
Head/Eyes: normocephalic, PERR, EOMI
ENT: normal nose
Neck: supple/no meningismus
Respiratory: symmetric chest expansion, no distress
Abdomen: no distention
Extremities: normal inspection, no edema
Musculoskeletal: normal inspection
Neuro/CNS: abnormal speech, right hemiparesis, alert, oriented X 3, PERRL

Skin: dry, intact

Speech
Speech: global aphasia (mild), dysarthric, speech apraxia

Mental Status
Orientation:
Yes: to person, to place, to time, to situation.
LOC: alert
Mental status: cooperates

Glasgow
Glasgow Coma Score

Glasgow Coma Score	Response	Value
Glasgow eyes:	eyes open spontaneously	4
Glasgow speech:	oriented	5
Glasgow motor:	obeys commands	6
Total		15

Cranial Nerves
Cranial nerves:
Abnormal: VII.

Cognitive Function
Cognitive function: good attention

Motor Testing
Motor testing 1:
Normal: bulk.
Motor Testing 2:
No asterixis, No dystonia, No fasciculations, No myoclonus, No myotonia, No tremor

Cerebellar Test
Nystagmus: absent

Results
Findings/Data:
Laboratory Tests

	02/26

	0647
Chemistry	
Sodium (135 - 146 MEQ/L)	140
Potassium (3.5 - 5.3 MEQ/L)	3.8
Chloride (98 - 107 MEQ/L)	108 H
Carbon Dioxide (20 - 33 MEQ/L)	28
Anion Gap (4 - 14)	4
BUN (7 - 25 MG/DL)	12
Creatinine (0.6 - 1.3 MG/DL)	0.9
GFR Calculation	>90
BUN/Creatinine Ratio (6 - 25 RATIO)	13.7
Glucose (70 - 115 mg/dl)	83
Calcium (8.5 - 10.1 MG/DL)	8.2 L
Phosphorus (2.5 - 4.9 MG/DL)	2.6
Magnesium (1.2 - 2.0 MEQ/L)	1.6

Laboratory Tests

	02/26 0647
Hematology	
WBC (3.9 - 10.6 K/mm3)	9.9
RBC (4.50 - 5.30 M/mm3)	4.53
Hgb (13.0 - 17.0 GM/DL)	13.4
Hct (37.0 - 49.0 %)	39.3
MCV (80.0 - 100.0 fl)	86.8
MCH (27.0 - 35.0 pg)	29.5
MCHC (31.0 - 37.0 g/dl)	34.0
RDW (11.5 - 14.5 %)	12.1
RDW Std Deviation (36.5 - 45.9 %)	37.2
Plt Count (150 - 450 k/cumm)	208
MPV (6.8 - 10.2 fl)	8.7

Results: labs reviewed

Diagnosis, Assessment & Plan

Free Text A&P:
s/p crescendo stereotypical TIAs
s/p large LMCA penumbra
occluded distal LMCA

volumetrically small final infarct

continues with clinical penumbra, that improves with layng flat;
please, low dose of lisinopril, and allow SBP to ride higher, he will have a gradual, over weeks normalization or lowering of the SBP.
Give bolus NS, and IV infusion

continue telemertry

aggressive 2ry prevention
d/c smoking

consider for inpatient acute rehab
may d/c today

f/u with PMD

Plan discussed with: intensivist, nurse, patient, spouse/partner

Electronically Signed by Jarquin-Valdivia,Adrian A MD on 02/26/16 at 1854

RPT #: 0226-1136
END OF REPORT

CENTENNIAL MEDICAL CENTER
2300 Patterson Street
Nashville, TN 37203

****DISCHARGE SUMMARY****

ROOM: M.7110-A
STATUS: DIS IN
PATIENT: RUFFINO,JOHN JAMES
MR#: M001949828
ACC#: M00158708946
DOB: 06/12/59
PHYSICIAN: Dolaptchiev,Bojidar B MD

DATE OF ADMISSION: 02/27/16
DATE OF DISCHARGE: 03/03/16

DATE OF ADMISSION:
February 27, 2016

DATE OF DISCHARGE:
March 3, 2016

PRINCIPAL DIAGNOSIS ON ADMISSION:
Acute ischemic stroke.

DISCHARGE DIAGNOSES:
1. Acute middle cerebral artery stroke.
2. Aphasia.
3. Right-sided weakness.

ADDITIONAL DIAGNOSES:
1. Hypertension.
2. Hyperlipidemia.
3. Benign prostatic hypertrophy.
4. Tobacco use.

CONSULTANTS:
Dr. Maria Dongas and Dr. Valdivia, neurology.

PROCEDURES:
None.

HISTORY OF PRESENT ILLNESS AND HOSPITAL STAY:
This 56-year-old white male with history of hypertension and BPH who was evaluated at Centennial Medical Center ER for increased right sided weakness and aphasia. He was not a candidate for TPA in the emergency room secondary timing. In the emergency room, the CT of the brain without contrast showed encephalomalacia in the deep white matter of the left frontal and temporal region suggesting prior infarction, no acute findings, has clinical signs of stroke and MRI ordered on February 28, 2016, showed acute scattered areas of strictly diffusion to suggest infarction involving the left periventricular white matter and left external capsule and left temporal lobe cortex. There is also chronic small vessel ischemic disease within the pons and periventricular white matter. The patient was started on aspirin. Physical therapy,

CENTENNIAL MEDICAL CENTER (COCCT) MAIN ER
EMERGENCY PROVIDER REPORT
REPORT#:0227-0982 REPORT STATUS: ESign
DATE:02/27/16 TIME: 1949

PATIENT: RUFFINO,JOHN JAMES UNIT #: M001949828
ACCOUNT#: M00158708946 ROOM/BED: ER - 04
DOB: 06/12/59 AGE: 56 SEX: PCP PHYS: NO PRIMARY OR FAMILY PHYSICIAN
ADM DATE: 02/27/16 INI AUTH: Cain,Terry W MD MD
LAST SIG:
REP SERV DT: 02/27/16 REP SERV TM: 1949
* ALL edits or amendments must be made on the electronic/computer document *

HPI-Stroke/CVA

General
Confirmed Patient Yes
Initial Greet Date/Time 02/27/16 1918

Presentation
Chief Complaint: Right Side increasing right sided weakness, increased aphasia
Onset of symptoms:
Date: 02/27/16
Time: 0430
Hx Obtained From Patient, Family
Sudden in Onset? Yes
Onset Occurred Today
Symptom Duration Since onset
Progression since Onset Gradually worsening
Associated with
Reports: Speech problem, Visual disturbance. Denies: Aura, Balance problem, Bladder dysfunction, Bowel dysfunction, Confusion, Double vision, Gait problem, Headache, Incontinence, Loss of consciousness, Loss of vision, Nausea, Neck pain, Syncope, Vertigo, Vomiting.

Context
Related History
Reports: Cerebrovascular accident.

Free Text HPI Notes
Free Text HPI Notes
56 yo presents with increasing right sided weakness, increasing dysarthria/aphasia. Began this am at 0430 when he fell while attempting to go the bathroom. Has gradually worsened since. Is not a tpa candidate secondary to recent stroke and onset greater than 4 hours ago. Was discharged from the hospital yesterday for a stroke of the left mca with total occlusion of m2 branch.

Risk-Stroke/CVA

Risk Stratification
Stroke Thrombolytic Therapy
TPA Considered No (contraindicated)
Neurologist Contacted Yes (Dr. Dongas)
TPA Administered Intravenously No, exclusion criteria
Exclusion Criteria Prior stroke/90 days
NIH Stroke Scale
Value 21
NIH Stroke Score Timing
Time 1930
Date 02/27/16

Review of Systems

ROS Statements
All systems rev & neg except as marked.
Complete sys rev & neg except as marked.

Basic Review of Systems
Basic ROS GU: No dysuria/frequency, HEM: No bleeding/bruising, ENDO: No cold/heat intol, ENDO: No weight gain/loss, ALL/IMMUNE: No allergy

Focused Review of Systems
Constitutional
Denies: Fever.
Respiratory
Denies: Cough, non-productive, Cough, productive, Dyspnea on exertion, Hemoptysis, Parox nocturnal dyspnea, Pleuritic pain, Shortness of breath, Wheezing.
Cardiovascular
Denies: Chest pain, Dyspnea on exertion, Edema, Orthopnea, Palpitations, Parox nocturnal dyspnea, Syncope.
GI
Denies: Abdominal pain, Nausea, Vomiting.
Neurologic
Reports: Focal weakness, Numbness, Unable to speak, Vision change. Denies: Abnormal movement, Bladder dysfunction, Bowel dysfunction, Change LOC, Confusion, Dizziness, Generalized weakness, Headache, Lightheaded, Problem walking, Seizure, Shaking, Slurred speech, Spinning sensation, Syncope, Tingling.

Past Medical History - Adult
Stated Complaint DECREASE IN CONDITION SINCE STROKE LAST THURS.
Allergies
Coded Allergies:
No Known Drug Intolerances (. 02/17/16)

Home Medications

Active Scripts
Clopidogrel (Plavix) 75 MG PO DAILY
#30
Prov: 02/26/16
Atorvastatin (Lipitor) 40 MG PO BEDTIME
#30
Prov: 02/26/16
Lisinopril (Prinivil) 20 MG PO DAILY
#30 TAB
Prov: 02/26/16
Aspirin 325 MG PO DAILY
#30
Prov: 02/26/16

Reported Medications
Tamsulosin (Flomax) 0.4 MG PO DAILY
Gabapentin (Neurontin) 300 MG PO DAILY 2100

Discontinued Reported Medications
Lisinopril (Zestril) 40 MG PO DAILY
Aspirin 81 MG PO DAILY
Atorvastatin (Lipitor) 10 MG PO DAILY
Ibuprofen (Motrin) 800 MG PO TID

Past Medical History:
Reports: Hyperlipidemia, Hypertension.
Past Surgical History:
Reports Cholecystectomy
Patient History
MOTHER
Family History: Cancer, Onset: 60+.
FATHER
Family History: Cancer, Onset: 60+.
Relation not specified for:
Family History: Unremarkable

Smoking status for patients 13 Never Smoker

Physical Exam

Initial Vital Signs
Vital Signs
First Documented:

	Result	Date Time
Pulse Ox	98	02/27 1920
B/P	150/76	02/27 1920
Temp	98.6	02/27 1920

Pulse	81	02/27 1920
Resp	16	02/27 1920

Last Documented:

	Result	Date Time
B/P	170/85	02/27 1927
Pulse Ox	98	02/27 1920
Temp	98.6	02/27 1920
Pulse	81	02/27 1920
Resp	16	02/27 1920

All vital signs available at the time of this entry have been reviewed.

Initial VS Reviewed

Focused PE

General/Const **

General/Const Awake, Alert, Well appearing, Well developed, Well hydrated, Well nourished, Cooperative, Not toxic appearing

Distress/Hydration

Distress moderate.

Head/Eyes **

Head/Eyes Atraumatic, Normocephalic, PERRL, EOMI, No nystagmus, No periorbital redness, No periorbital swelling, No photophobia, No scleral icterus, Conjunctiva NL, Cornea clear, No corneal abrasion

Neck **

Neck Atraumatic, Supple, No meningismus, Full range of motion, No adenopathy, No swelling, Non-tender, No midline vertebral tend, No masses, No crepitus, No JVD, No carotid bruit, Thyroid NL, No tracheal deviation

Resp/Chest **

Respiratory/Chest Atraumatic, Breath sounds NL, Breath sounds = bilat, No respiratory distress, No rales, No rhonchi, No wheezing, No retractions, No stridor, No chest tenderness, No chest wall deformity, No crepitus

Cardiovascular **

Cardiovascular Heart rate NL, Regular rhythm, Heart sounds NL, No gallop, No murmurs, No rubs, Cap refill not delayed, Peripheral circulation NL, Pulses = bilaterally, No gross BP differential

Neurologic **

Neurologic Oriented X3

Speech

Garbled, Expressive aphasia.

Cranial Nerve Deficit

6 - lateral gaze asym, 7 - upper/asymetric frown, 7 - lower/asymetric smile.

Focal Weakness

Upper extremity R, Lower extremity R.

Sensory Deficit

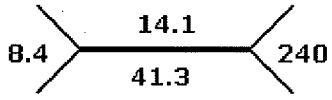
Upper extremity R, Lower extremity R.

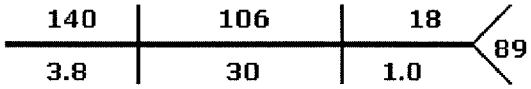
Interpretation & Diagnostics

Lab Results Interpretation

Considerations Independ review imaging, Reviewed prior records
Results
Laboratory Tests

02/27/16 1931:





Laboratory Tests:

	02/27 1931	02/27 1935	02/27 1936
Chemistry			
Sodium (135 - 146 MEQ/L)	140		
Potassium (3.5 - 5.3 MEQ/L)	3.8		
Chloride (98 - 107 MEQ/L)	106		
Carbon Dioxide (20 - 33 MEQ/L)	30		
Anion Gap (4 - 14)	4		
BUN (7 - 25 MG/DL)	18		
Creatinine (0.6 - 1.3 MG/DL)	1.0		
GFR Calculation	>90		
BUN/Creatinine Ratio (6 - 25 RATIO)	18.9		
Glucose (70 - 115 mg/dl)	89		
POC Glucose (70 - 115 mg/dL)		89	
Calcium (8.5 - 10.1 MG/DL)	8.7		
Corrected Calcium (8.4 - 10.2 mg/dl)	9.1		
Total Bilirubin (0.0 - 1.3 MG/DL)	0.4		
AST (8 - 46)	16		
ALT (7 - 60)	50		
Alkaline Phosphatase (45 - 117)	104		
Troponin I (<0.02 - 0.079 ng/mL)			<0.02 L
Total Protein (6.4 - 8.2 GM/DL)	7.8		
Albumin (3.5 - 5.5 GM/DL)	3.7		
Globulin (2.2 - 4.2 G/DL)	4.1		
Albumin/Globulin Ratio (0.8 - 2.0)	0.9		
Coagulation			
PT (9.4 - 11.3 SECONDS)	10.1		
INR (0.9 - 1.1 RATIO)	1.0		
PTT (Anticoag Therapy) (24.9 - 32.4 SECONDS)	28.2		
Hematology			
WBC (3.9 - 10.6 K/mm3)	8.4		
RBC (4.50 - 5.30 M/mm3)	4.76		
Hgb (13.0 - 17.0 GM/DL)	14.1		

Hct (37.0 - 49.0 %)	41.3		
MCV (80.0 - 100.0 fl)	86.8		
MCH (27.0 - 35.0 pg)	29.6		
MCHC (31.0 - 37.0 g/dl)	34.1		
RDW (11.5 - 14.5 %)	12.2		
RDW Std Deviation (36.5 - 45.9 %)	37.2		
Plt Count (150 - 450 k/cumm)	240		
MPV (6.8 - 10.2 fl)	8.7		
Absolute Nucleated RBC (0.00 - 0.03 K/mm3)	0.00		
Neutrophils % (50 - 70 %)	70.5 H		
Lymphocytes % (18 - 42 %)	18.7		
Monocytes % (2 - 11 %)	8.6		
Eosinophils % (1 - 3 %)	1.5		
Basophils % (0 - 2 %)	0.7		
Neutrophils # (1.8 - 8.0 K/mm3)	5.9		
Lymphocytes # (1.0 - 4.8 K/mm3)	1.6		
Monocytes # (0.1 - 0.6 K/mm3)	0.7 H		
Eosinophils # (0 - 0.5 K/mm3)	0.1		
Basophils # (0 - 0.1 K/mm3)	0.1		
Nucleated RBCs (0.0 - 0.6 %)	0.0		
Morphology Comment	NORMAL INDICATED		

Recent Impressions:
COMPUTERIZED TOMOGRAPHY - CT HEAD W/O CONTRAST 70450 02/27 1944
*** Report Impression - Status: SIGNED Entered: 02/27/2016 1947

Impression:
1. Encephalomalacia in the deep white matter of left frontal and temporal regions suggesting prior infarction.
2. No acute intracranial findings.
Impression By: DR.BURKE1 - Kevin Burner
RADIOLOGY - XR CHEST 1 VIEW PORT 71010 02/27 1955
*** Report Impression - Status: SIGNED Entered: 02/27/2016 2006

Impression:
1. No acute findings.
Impression By: DR.BURKE1 - Kevin Burner

Lab & Imaging Statement
Laboratory & radiographic studies reviewed and considered in the medical decision-making.

Point of Care Testing
Pulse Oximetry
Pulse Ox % 97
On: Room air
Interpretation Interpreted by me, Pulse oximetry normal

ECG #1 Interpretation
Interpreted by ED physician
NL ECG Interpretation Normal rate, Normal sinus rhythm, No acute ischemic changes, No STEMI

Lab Studies
CBC Interpretation CBC NL
BMP/CMP Interpretation BMP/CMP NL
Cardiac and Vascular Interpretation Troponin NL
Serum Coags Interpretation Coags NL

Radiography
X-Ray Chest
View Portable
Interpretation/Wet Read by Interpret - ED physician
NL CXR Findings No acute disease
CT Head
Interpretation/Wet Read by Interpret - Radiologist
Reviewed by ED physician
NL Head CT Findings No acute disease, encephalomalacia of the l mca distribution

Re-Evaluation & MDM

ED Course
Time 2031
Patient Course Stable
Medication(s) Ordered
Medication(s) Ordered:
Electrolytic, Caloric, And Wat

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Sodium Chloride	1,000 ML	X1ED ONE IV	02/27 1933 02/27 2032	DC	02/27 1954

Re-Evaluation/Progress #1
Time of Re-Eval 2032
Re-Eval Status Unchanged

Consultation
Consultation
Referral/Consultant Name
Dongas,Maria F MD
Consultant Will see patient

Patient Discharge & Departure

Vital Signs/Condition
Vital Signs
First Documented:

	Result	Date Time
Pulse Ox	98	02/27 1920
B/P	150/76	02/27 1920
Temp	98.6	02/27 1920
Pulse	81	02/27 1920
Resp	16	02/27 1920

Last Documented:

	Result	Date Time
B/P	170/85	02/27 1927
Pulse Ox	98	02/27 1920
Temp	98.6	02/27 1920
Pulse	81	02/27 1920
Resp	16	02/27 1920

All vital signs available at the time of this entry have been reviewed.

Condition Stable

Clinical Impression
Clinical Impression
Primary Impression: Stroke

Disposition Decision
Admit
Admit Physician Name
Mustapha,Taopheeq A MD
)(**Admission Accepts** Yes

Electronically Signed by Cain,Terry W MD on 02/27/16 at 2053

RPT #: 0227-0982
END OF REPORT